SCHEDULING MANIPULATION AND VETERAN DEATHS IN PHOENIX: EXAMINATION OF THE OIG'S FINAL REPORT

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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Wednesday, September 17, 2014

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The committee met, pursuant to notice, at 1:19 p.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [chairman of the committee] presiding.

Present: Representatives Miller, Lamborn, Bilirakis, Roe, Denham, Runyan, Benishek, Huelskamp, Coffman, Wenstrup, Cook, Walorski, Jolly, Michaud, Brown, Takano, Brownley, Titus, Kirkpatrick, Ruiz, Negrete McLeod, Kuster, O'Rourke, and Walz.

Also Present: Representative Schweikert.

OPENING STATEMENT OF CHAIRMAN JEFF MILLER

The CHAIRMAN. Good afternoon. This hearing will come to order. I thank everybody for attending this hearing which will examine the OIG report on the Phoenix issue.

I would also like to ask unanimous consent, he is not here yet, but that our colleague, David Schweikert, from Arizona, be allowed to join us here to address this issue. Without objection, so ordered.

Also, Members, we do have a series of votes that will start at one o'clock. I apologize for that. This hearing was moved from its original scheduled time because of the joint session of Congress to hear the President of the Ukraine.

What we will do is immediately after the final vote move back as quickly as you can. We will resume the hearing as quickly as we possibly can so that we will not keep the witnesses waiting any longer than absolutely necessary.

On the 26th of August, the VA Office of Inspector General released its final report on the Phoenix VA Healthcare System which vaulted to national attention after our hearing on April the 9th.

The OIG confirmed that inappropriate scheduling practices are a nationwide systemic problem and found that access barriers adversely affected the quality of care for veterans at the Phoenix VA Medical Center.

Based on the large number of VA employees who were found to have used scheduling practices contrary to Veterans Health Administration policy, the OIG has opened investigations, as I understand it, at 93 VA medical facilities and have found over 3,400 veterans

who may have experienced delays in care from wait list manipulation at the Phoenix VA Medical Center alone.

The OIG concluded by providing the VA with 24 recommendations for improvement to avoid these problems from reoccurring. These recommendations should be implemented immediately, and this committee will work tirelessly to ensure that they are, in fact, implemented.

Mr. Griffin, I commend you, sir, and your team for your work and continued oversight on these issues in the past and in the months ahead. With that said and as we have discussed, I am discouraged and concerned the manner with which the OIG report, the final report was released along with the statements contained within it.

Notably, prior to the release of the report, selective information was leaked to the media apparently by a source internal to VA which I believe purposely misled the public that there was no evidence at Phoenix linking delays in care with veteran deaths. And as the days progressed and people actually read the report, that falsehood actually became obvious.

What the OIG actually reported and what will be the subject of much discussion today is the statement by the OIG, quote, "We are unable to conclusively assert that the absence of timely, quality care caused the deaths of these veterans," end quote.

Now, what is most concerning to me about this statement is the fact that no one who dies while waiting for care would have delay in care listed as the cause of death since a delay in care is not a medical condition.

Following the release of this report which found pervasive problems at the facility regarding delays in care and poor quality of care, committee staff was briefed by the OIG regarding its findings and how specific language was chosen throughout the entire drafting process.

Prior to this meeting, we requested that the OIG provide us with the draft report in the form it was originally provided to VA three weeks before the release of the final report. After initially expressing reservations, the OIG provided us with the draft. What we found was that the statement that I just quoted was not in the draft report at all.

Another discrepancy we found between the draft and final reports arose with statements to the effect that one of the whistleblowers here today did not provide a list of 40 veterans who had died while on a waiting list at the Phoenix VA Medical Center.

First, the OIG statement in the briefing to the committee staff that VA inquired why such a statement was not in the report and the OIG ultimately chose to include it.

Further, additional information provided by the OIG to our committee staff shows that based on numerous lists provided by all sources throughout the investigation, the OIG, in fact, accounted for 44 deaths on the electronic wait list alone and an astonishing 293 total veteran deaths on all of the lists provided from multiple sources throughout this review.

To be clear, it is not nor was not my intention to offend the inspector general and the hard-working people within the agency that he employs. However, I think I would be remiss in my duty

to conduct oversight of the Department of Veterans Affairs if I did not ask these questions.

I would also like to point out that no one within the department or any other Federal Government employee including Members of this committee is beyond having their records scrutinized. As such, the committee will continue to ask the questions that need to be asked in order to perform our constitutional duties.

It is absolutely imperative that the OIG's independence and integrity in its investigation be preserved. Full and transparent hearings like this one will help ensure that that remains the case.

With that, I now turn to the ranking member, Mr. Michaud, for his opening statement.

[THE PREPARED STATEMENT OF JEFF MILLER, CHAIRMAN APPEARS IN THE APPENDIX]

STATEMENT OF MICHAEL MICHAUD, RANKING MEMBER

Mr. MICHAUD. Thank you very much, Mr. Chairman, for having this very important hearing.

I would like to thank all the panelists for coming today as well.

Today's hearing provides the opportunity to examine the VA inspector general's final report on the patient wait times and scheduling practices within the Phoenix VA Healthcare System. This report did not state a direct causal relationship between the long patient wait times and veterans' death. For some, that is a major concern and accusation of undue influence by the VA on the inspector general's report will be discussed at length today.

What the IG did find is that the cases included in this report clearly shows that there was serious lapse in VA's follow-up, coordination, quality, and continuum of care for our veterans. They also concluded that the inappropriate scheduling practices demonstrated in Phoenix are a nationwide systematic problem.

I do not need any more evidence or analysis that there is no doubt in my mind that veterans were harmed by the scheduling practices and culture at the Phoenix facility and across the Nation.

The bottom line is this behavior and the detrimental effect of veterans is simply not acceptable. My heart goes out to the families of the veterans who did not receive the healthcare they deserved in Phoenix and around the country. Rest assured that we will understand what went wrong, fix it, and hold those responsible for these failures accountable.

As such, my question to the VA today is straightforward. What went wrong? What are you doing to fix the problems? How will you ensure that this never happens again and how are you holding those responsible accountable?

I applaud Secretary McDonald for taking forceful action to begin to address the systematic failures demonstrated in Phoenix. We need serious, deep, and broad reform, that kind of change that may be uncomfortable for some in VA, but so desperately needed by America's veterans.

I believe that such reforms must be guided by a higher level national veteran strategy that outlines a clear vision of what America owes its veterans and a set of tangible outcomes that every component of American society can align and work towards.

Earlier this week, I sent a letter to President Obama asking him to establish a working group to engage all relevant members of the society in drafting this national veteran strategy.

We know from experience that VA cannot do it alone. We must develop a well-defined idea on how the entire country, government, industry, nonprofits, foundations, communities, and individuals, will meet this obligation to our veterans.

VA needs to become a veteran-focused, customer service organization. It needs to be realigned to become the integrated organization. It should do what it does best and partner for the rest. It needs to be the government model for honesty, integrity, and discipline.

We need to complete our investigation of these problems and provide oversight on the solutions. And I look forward to today's additional testimony about what happened in Phoenix and how the VA is working to ensure that it never happens again.

So, once again, Mr. Chairman, I want to thank you for having this hearing and I yield back the balance of my time.

[THE PREPARED STATEMENT OF MICHAEL MICHAUD, RANKING MEMBER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much.

And I would ask that all Members waive their opening statements as customary in this committee.

Thank you to the witnesses that are here at the table and those that agreed to sit behind the principles.

Today we are going to hear testimony from Acting Inspector General Richard J. Griffin who is accompanied by Dr. John Daigh, Jr., assistant inspector general for Healthcare Inspections; Ms. Linda Halliday, assistant inspector general for Audits and Evaluations; Ms. Maureen Regan, counselor for the inspector general; and Larry Reinkemeyer, director of the Kansas City Office of Audits for the Office of Inspector General.

We are also going to hear from Dr. Samuel Foote, a former VA physician at Phoenix VA Healthcare System and Dr. Katherine Mitchell, current whistleblower and medical director for the Iraq and Afghanistan Post-Deployment Center at the Phoenix VA Healthcare System.

I would ask the witnesses now to please stand so that we may swear you in. If you would raise your right hands.

[Witnesses sworn.]

The CHAIRMAN. Thank you. You may be seated.

Let the record reflect that all of the witnesses affirmed that they would, in fact, tell the truth, the whole truth, and nothing but the truth.

All of your complete written statements will be made a part of this hearing record.

And, Mr. Griffin, you are now recognized for five minutes.

STATEMENT OF RICHARD J. GRIFFIN

Mr. GRIFFIN. Mr. Chairman, Ranking Member Michaud, and Members of the committee, thank you for the opportunity to discuss the results of the inspector general's extensive work at the Phoenix VA Healthcare System.

Our August 26, 2014 report expands upon information previously provided in our May 2014 interim report and includes the results of the reviews of the OIG clinical staff of patient medical records.

We initiated our review in response to allegations first reported through the OIG hotline on October 24, 2013 from Dr. Foote who alleged gross mismanagement of VA resources, criminal misconduct by VA senior hospital leadership, systemic patient safety issues, and possible wrongful deaths at Phoenix.

The transcript of our interview with Dr. Foote has been provided to the committee and I request that it be included in the record.

The CHAIRMAN. Without objection.

Mr. GRIFFIN. We would like to thank all the individuals who brought forward their allegations about issues occurring at Phoenix and at other VA medical facilities to the attention of the IG, the Congress, and the Nation.

On August 19, 2014, the chairman of the Subcommittee on Oversight and Investigations sent a letter to the IG requesting the original copy of our draft report prior to VA's comments and adopted changes to the report.

On September 2nd, a committee staff member made a similar request for a written copy of the original unaltered draft as first provided to VA on behalf of the chairman.

Concerns seemed to come from our inclusion of the following sentence in a subsequent draft report that was not in the first draft report we submitted to VA. The sentence reads as follows:

While the case reviews in this report document poor quality of care, we are unable to conclusively assert that the absence of timely care caused the death of these veterans.

This sentence was inserted for clarity to summarize the results of our clinical case reviews that were performed by our board certified physicians whose curricula vitae are an attachment to our testimony.

It replaced the sentence the death of a veteran on a wait list does not demonstrate causality which appeared in a prior draft, not the first draft that was requested, but in a subsequent draft. This change was made by the OIG strictly on our own initiative. Neither the language nor the concept was suggested by anyone at VA to any of my people.

In the course of our many internal reviews of the content of our draft report, on July 22nd, almost a full week before the draft was sent to the department, one of our senior executives wrote this question. This is key, gentlemen and ladies.

And I quote. "Did we identify any deaths attributed to significant delays?" This was on July 22nd. If we can't attribute any deaths to the wait list problems, we should say so and explain why. After all, the exact wording in the draft report was were the deaths of any of these veterans related to delays in care.

This type of deliberation to ensure clarity continued as it should after the initial draft was sent to the department. In the last six years, we have issued more than 1,700 reports. This same review and comment process has been used effectively throughout OIG history to provide the VA secretary and Members of Congress with independent, unbiased, fact-based program reviews to correct identified deficiencies and improve VA programs.

These reports have served as the basis for 67 congressional oversight hearings including 48 hearings before this committee.

During these same six years, our work has been recognized by the IG community with 25 awards for excellence. We are scrupulous about our independence and take pride in the performance of our mission to ensure veterans receive the care, support, and recognition they have earned through service to our country.

The VA secretary has acknowledged the department is in the midst of a serious crisis and has concurred with all 24 recommendations and has submitted acceptable corrective action plans.

Our recent report cannot capture the personal disappointment, frustration, and loss of faith that veterans and their family members have with the healthcare system that often could not respond to their physical and mental needs in a timely manner.

Although we did not apply the standards of determining medical negligence during our review, our findings and conclusions in no way affect the rights of a veteran or his or her family from filing a complaint under the Federal Tort Claims Act with VA.

Decisions regarding VA's potential liability in these matters lies with the VA, the Department of Justice, the judicial system under the Federal Tort Claims Act.

Mr. Chairman, this concludes our statement. We would be happy to answer any questions you or other Members of the committee may have.

[THE PREPARED STATEMENT OF RICHARD J. GRIFFIN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Mr. Griffin.

Dr. Foote, you are recognized for your opening statement for five minutes.

STATEMENT OF SAMUEL H. FOOTE

Dr. FOOTE. My name is Dr. Sam Foote. I started my internal medicine training in 1981 at the combined Good Samaritan Phoenix VA program. I finished in 1984 and became board certified in internal medicine.

I went to work full time in East Mesa, Arizona as an emergency physician and I returned to the VA in 1990, the same year that I earned by boards in emergency medicine. I ran the VA's emergency department from 1990 to 1998. I was a medical service teaching attending from '91 to 2003 and I became an outpatient clinic director on December of 1994, a position which I held until my retirement in December of 2013.

While I have views on many aspects of what has come to be known as the VA scandal, I would like to use this statement to comment on what I view as the foot dragging, downplaying, and, frankly, inadequacy of the Inspector General's Office.

This continues in the report issued August 26, 2014 which I fear is designed to minimize the scandal and protect its perpetrators rather than provide the truth along with closure to the many veterans and families that have been affected by it.

All VA employees receive mandatory recurrent training on their duty to report waste, fraud, and abuse to the inspector general whose job it is to investigate these allegations. I first did this in

February of 2011 which resulted in then director Gabriel Perez being placed on leave within two weeks of the IG receiving my letter and a few months later, his resignation in lieu of termination.

I sent a second letter to the IG in April of 2013 where I made allegations against the chief of Health Administrative Services, Brad Curry, for creating a hostile workplace, engaging in prohibitive personnel actions and discrimination against certain classes of employees.

As far as I can tell, the IG never investigated this complaint and it appears that they turned it over to the Veterans Integrated Service Network director, Susan Bowers, who was both Helman's and Curry's superior. Susan Bowers could not take action against him without running the risk that the entire waiting list scandal would be exposed.

In late October of 2013, I sent a third letter to the IG informing them of the existence of a secret waiting list where ten patients on that list had died while waiting for appointments.

I also included additional allegations of prohibitive personnel actions by senior staff. Furthermore, I advised them of a second hidden backlog of patients contained in the scheduling appointment with primary care consult lists and that an unknown number of veterans had perished on it.

I also detailed other methods that were used—in use to lower the apparent backlog for new patients and I implored the IG to come to Phoenix to investigate all the above. I got a response from the San Diego IG Office on December 3rd, 2013 to join a conference call with them on December 6th.

Their team came out to investigate the week of December 16th through the 20th. At that time, I and others told them about the unaddressed scheduling appointment consults and showed them the Northwest Electronic Holding Clinic which was being used as were prior holding clinics to mask the true demand for return patient appointments.

We updated them on the secret electronic waiting list summary report showing that 22 patients had been removed from it because they had died. We only had the names of two of the deceased because none of the employees who were working with me had the electronic keys to print the names of the deceased.

We asked the IG inspectors if they could do it, but they responded that they could not. The last email response that I had from them was on December 21st, 2013 when I received an out of the office until Tuesday, December 31st, 2013 reply.

I had offered to fax or mail the names we had at the time, but they were unable to give me a working fax number or an address to mail it to. Fax and standard mail but not unencrypted email are considered appropriate methods to transmit HIPAA sensitive materials.

I sent four more emails in early January again asking if they would like me to fax or mail the patients' names, but I got no response. I also got no response when I advised them that several more veterans had died.

Finally, on February 2nd, 2014, out of frustration, with lack of action by the IG, even though we were informing them of more and more deaths, I sent IG letter number four with copies to everyone

who I could think of that might be able to help. The only response that I got from the IG was a confirmation that they had received my letter.

A friend suggested that I contact the House Veterans' Affairs Committee and there I found the help I needed. During this process, I was advised by several people that the only way I could get the IG's Office to investigate my allegations was to make them public which reluctantly I did.

In my opinion, this was a conspiracy, possibly criminal, perpetrated by senior Phoenix leaders. Of the many scandalous aspects from the performance bonuses paid to top administrators for supposedly meeting waiting time goals to the harassment of employees trying to rectify the situation to the destruction of documents and electronic records to the very real harm done to the health of thousands of veterans unable to receive timely medical care, nothing is more scandalous than the fact, the fact that 293 veterans died in Phoenix.

Yet, even now, right here in this report, the inspector general tries to minimize the damage done and the culpability of those involved by stating that none of the deaths can be conclusively tied to treatment delays.

I have read the report many times and several things bother me about it. Throughout the case reports, the authors appear to have downplayed facts and minimized the harm. This was absolutely true in cases six and seven where I have direct knowledge.

After reading these two cases, it leaves me wondering what really happened in all the rest. For example, in case number 29, how could anyone conclude that the death was not related to the delay when a patient who needs an implanted defibrillator to avoid sudden death did not get one in time and why was a cardiac death case excluded from the IG review?

In addition, a critical element to proving that this was a conspiracy was the potential tampering with the reporting software of the electronic waiting list. From the beginning, the IG's own data showed that there was a difference between the numbers reported to Washington and what the numbers actually were on the secret electronic waiting list.

The IG clearly minimized the significance of the crucial—of this crucial point treating it as a trivial—as a trivial clerical error and touting how quickly the IT department corrected it rather than exploring who tampered with it in the first place.

Adding it up, the IG report states 4,900 veterans were waiting for new patient appointments at the Phoenix VA. Three thousand five hundred were not on any official list and—and 1,400 were on the non-reporting secret electronic waiting list. Two hundred and ninety-three of these veterans are now deceased.

This vastly exceeds my original allegations that up to 40 veterans may have died while waiting for care. The IG says it is not charged with determining criminal conduct. True. But neither is it charged with producing reports designed to downplay potential criminal conduct designed to defuse and discourage potential criminal investigations or to diminish the quite appropriate public outrage.

At its best, this report is a whitewash. At its worst, it is a feeble attempt at a coverup. The report deliberately uses confusing language and math, invents new unrealistic standards of proof, ignores why the electronic waiting list was not reporting accurate data, and makes misleading statements.

In addition, the attempts to minimize bad outcome by downplaying damaging information and thereby protecting the VA officials who are responsible for this scandal just reinforces the VA's longstanding culture of circling the wagons to delay, deny, and let the claim, story, or patient die that the veterans community has had to suffer with for years.

The CHAIRMAN. Dr. Foote, I apologize. You have gone three minutes over the five. I would like to say that the rest of your testimony will be entered into the record. I apologize, but I let you go a little bit longer than what we all had agreed to.

Can you wrap it up in the next 20 seconds?

Dr. FOOTE. Yeah. Secretary McDonald said that he was going to try to increase the transparency of the agency and that he would not tolerate whistleblower retaliation. Apparently some senior Washington VA administrators did not get that memo. This report fails miserably in those areas with a transparency equivalent to a lead-lined, four foot thick concrete wall.

Thank you, Mr. Chairman.

[THE PREPARED STATEMENT OF SAMUEL H. FOOTE APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Doctor.

Dr. Mitchell, you are recognized for five minutes.

STATEMENT OF KATHERINE L. MITCHELL

Dr. MITCHELL. I'm deeply honored by the committee's invitation to testify today. The OIG wasn't able to conclusively assert that the absence of timely quality care caused veterans' death.

As a physician reading the report, I disagreed. Specifically in a minimum of five cases, I believe there was a very strong actual or potential causal relationship between delayed care or improper care and veteran death.

In addition, healthcare delays contributed to the quality of life and for five other veterans who were terminally ill and shortened the life span of one of them.

In looking at the report, there are four cases where there is no cause of death listed. It's unclear to me how a causal relationship may or may not exist if there is no cause of death given.

It is unclear if 19 veterans who were on the electronic waiting list were aware of the self-referral process to the primary care clinics. If they were not aware of this process, then they reasonably—reasonably believed that waiting on the waiting list was the only way to get medical care even if their symptoms were worsening.

In two cases, the OIG gave evidence that the veterans' acute or had acute instability of their chronic medical disease that required repeated visits to the ER and hospitalization. I believe that those likely—those delays likely contributed to their death. But, again, the OIG did not give a cause of death for those two veterans.

In terms of mental health treatment, there were eight veterans on the electronic waiting list waiting for primary care who appar-

ently just wanted a mental health referral. Two of those veterans committed suicide before they got the appointment.

It is unclear if anyone told them that the mental health process is a self-referral process and they could have done so any regular business day and initiated mental healthcare.

In case number 29, there was a veteran that needed a life-saving medical device implanted under his skin that would immediately shock his heart into a normal rhythm if his heart stopped. The community standard would have been to implant this device immediately. At the VA, he waited four months and still did not have an appointment.

Unfortunately, the veteran's heart did stop and without the device, he had to wait precious minutes for the paramedics to arrive to restart it. He was revived, but, unfortunately, the family had to withdraw life support three days later.

The OIG stated that this device might, quote, "might have forestalled death," end quote. It's very apparent that it would have fore—I'm sorry—it would have forestalled death because the implantable device is exactly what's used to treat the lethal heart rhythm that he had. He died from complications of prolonged heart stoppage without the device that could have restarted his heart in seconds. He was denied access to specialty care.

In case 39, a veteran with multiple risk factors for suicide came to the ER with intense emotional stressors including being homeless. He was put on psychiatric meds to stabilize him, but he was discharged back to the streets. He committed suicide 24 hours later.

The community standard would have been to admit this unstable veteran. The OIG admitted that it would have been, quote, "a more appropriate management plan," end quote, to admit this patient, but did not draw a connection between inappropriate mental health discharge from an ER and death from suicide within 24 hours.

Case number 31, he died of metastatic prostate cancer that was not treated during the seven-month period that the VA failed to act on the abnormal lab. While his metastatic prostate cancer could not have been cured, earlier detection would have started the treatment that would have slowed down the progression of the disease significantly and slowed the painful spread of cancer to his bones.

Because of unavailable urology appointment and missed labs, this veteran was denied timely access to specialty care that would have forestalled his death by months if not longer.

In case 36, this veteran didn't receive timely, quality care for evaluation of unrelenting severe pain that clearly served as the impetus for his suicide.

In case 40, there was a premature discharge from a psychiatric ward for an unstable patient with multiple suicide risk factors that enabled the death from suicide 48 hours later.

There are many other cases that I reviewed in my written testimony. I did not discern a difference between death on the electronic waiting list and death waiting for appropriate medical care for those who were already in the system. Death is death and there is no way to get those veterans back.

The purpose of my testimony is not to undermine the VA or the OIG. The purpose is to get the VA to examine its practices and in

order to improve the quality of healthcare for veterans. They have to repair the cracks in the system so no more veterans slip through.

Thank you very much for your time.

[THE PREPARED STATEMENT OF KATHERINE L. MITCHELL APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much to everybody for your testimony.

Mr. Griffin, in the information you provided to the committee or your office has provided, it shows that 28 veterans died while on the NEAR list or the new enrollee appointment request, essentially meaning they died while waiting to get their foot in the door at VA.

And since these veterans were not yet in the VA system, your staff briefed us that the OIG used Social Security records which only show that the individual had died, not how they died; is that correct?

Mr. GRIFFIN. I would say that we sought a lot of additional information from Social Security. We—we sought to find death records from the coroner's office. We explored who might have been getting treatment under the Medicare program. But as far as the specifics on—on those deaths, I would defer to Dr. Daigh.

The CHAIRMAN. Dr. Daigh, could you answer that question?

Dr. DAIGH. Sure. The determination of—excuse me—the determination of death was by and large made from looking at the medical record and the death certificate was—was mostly how we were able to identify, A, that a patient clearly had died, the record was correct, and by reading both the medical record and the, in several cases, the records of their care at local hospitals.

The CHAIRMAN. If you are on the NEAR list, is there a medical record?

Dr. DAIGH. No. The NEAR list is a—is a tremendous problem. Patients on the NEAR list would have tried to enroll to VA and may not have ever been seen at VA. So you're absolutely right. Anyone that's on the NEAR list that did not make it through the wickets at Phoenix to be seen and does not have a medical record, I can't look at. So—so those folks I'm not able to examine if they don't have a record, I mean, if I have no contact with them.

The CHAIRMAN. If that is true, then how can you conclusively or otherwise determine whether these deaths were related to delays in care?

Dr. DAIGH. Well, in the cases that we identified that we were able to actually review——

The CHAIRMAN. Wait. The report says, conclusively says this is where we have some problems——

Dr. DAIGH. Right.

The CHAIRMAN [continuing]. Mr. Griffin, is that there were people that were looked at in the report and your report says conclusively that there is no link to delays in care and death, yet there are individuals that you were not able to go back and look definitively at their medical record to determine what the cause of death was or if there was a delay in care; is that correct?

Dr. DAIGH. In the report, we are trying to address the patients that we identified who had a delay in care and then subsequently received poor quality care as a result of that delay.

The CHAIRMAN. But if you were on the NEAR list——

Dr. DAIGH. Correct.

The CHAIRMAN [continuing]. Is that a delay in care? If you did not get into the system, is that a delay?

Dr. DAIGH. Yes.

The CHAIRMAN. Okay. Then how can you conclusively say that none of the delays were a cause of death?

Dr. DAIGH. Well, we were referring to the universe of patients that we were able to look at, so the universe——

The CHAIRMAN. If you didn't look at all of them——

Dr. DAIGH. No. I'm—I'm saying that—that I provided your staff with a breakout of——

The CHAIRMAN. Did——

Dr. DAIGH [continuing]. Exactly——

The CHAIRMAN. Did you——

Dr. DAIGH [continuing]. The various——

The CHAIRMAN. I am sorry, Dr. Daigh. Were you able to look conclusively at all of those that were on the wait lists?

Dr. DAIGH. I'm only able to look at those—I looked at 3,000——

The CHAIRMAN. Yes or no, were you able to conclusively look at all of the people that were on wait lists?

Dr. DAIGH. No. If—if the NEAR is considered——

The CHAIRMAN. Thank you. That is——

Dr. DAIGH. Yes.

The CHAIRMAN. I want to direct you to an email from Dr. Deering found on page 38 of your report regarding a veteran who died while waiting for care. And it has already been talked about this morning. And in a staff briefing on the 4th, you stated that the veteran was seen by a urologist within three days of presenting to the ER, so his case was not included in the 45 case reviews in the report.

However, we received notification from the OIG yesterday stating that a mistake had been made, that this veteran was actually not seen after he was presented at the ER. And after informing us of this delay, the OIG still says that this delay in care did not contribute to his death.

Could you explain to me how the OIG came to this conclusion?

Dr. DAIGH. So the patient in question has bladder cancer and had bladder cancer for many years. He arrived at the VA and was seen in the emergency room initially and received a very reasonable emergency room evaluation.

Among his chief complaints were that he had blood in his urine. He also had chronic rheum—he had rheumatoid arthritis and some other disabilities including amputation of the leg.

As a result of that visit, his urine was looked at and he had microscopic hematuria. He also did need to see a rheumatologist, and he did not have a primary care provider. So the ER physician asked that this gentleman have several consults, a vascular surgery consult, rheumatology consult, and a—and a urology consult and a primary care consult.

The records, and this is the source of the confusion, the VA records state that he had an appointment made for urology to be held on 10/22/13. It says that the patient called and requested a rescheduling of that appointment which was then rescheduled for 11/06/13. He no showed for that appointment.

So in our discussions, some people would say the patient had an appointment to see urology and didn't keep his appointment.

The CHAIRMAN. But——

Dr. DAIGH. But——

The CHAIRMAN [continuing]. I understand.

Dr. DAIGH. [continuing]. My clarification to the staff that——

The CHAIRMAN. Let me ask a question real quick.

Dr. DAIGH. Yes, sir. Yes.

The CHAIRMAN. And I will let you finish. I apologize. Nobody here in this room has any faith in any of the appointments and scheduling that was going on at that time, so I have no belief that what may have been written was, in fact, true.

Dr. DAIGH. I understand that.

The CHAIRMAN. So please continue.

Dr. DAIGH. And—and so from—what I'm saying is this gentleman then died of what appears to be by image metastatic cancer where he had metastasis to his brain and he appeared to also, I believe, have cancer in his lung.

So the assertion that having seen a primary care provider in the six or eight weeks between the emergency room visit and when he died, I don't believe that that primary care provider would have—that visit would have changed his death.

And I'd refer you to page 75 or 76 of the testimony that we provided from the transcript of Dr. Foote.

The CHAIRMAN. If I may, if I may also——

Dr. DAIGH. Yes, sir.

The CHAIRMAN [continuing]. Interrupt, the testimony was given to us as the hearing had already started. We hadn't even had a chance to look at it. We just got it handed to us——

Dr. DAIGH. Yes, sir. I'm just saying——

The CHAIRMAN [continuing]. In the hallway after the gavel dropped.

Dr. DAIGH. Well, sir, I'm just saying that on——

Mr. GRIFFIN. That was sent up here electronically earlier in the day and it was sent up to—to make sure the truth was on the record having seen other witnesses' testimony and needing to make sure that the committee was fully aware that we had a taped transcript of our interview.

The CHAIRMAN. And that——

Mr. GRIFFIN. And I think people should take a hard look at that transcript.

The CHAIRMAN. I appreciate it very much, but your staff told us there was a formatting problem getting it to the committee and that is why we just got it.

Mr. GRIFFIN. Are you referring to the transcript of the interview of Dr. Foote?

The CHAIRMAN. That is what I am referring to. Any other transcripts I need to be aware of?

Mr. GRIFFIN. No. I believe we sent all the rest of the information up 48 hours in advance.

The CHAIRMAN. Let me ask you, Mr. Griffin, Dr. Foote's original allegation was up to 40 veterans may, may have died while awaiting care at Phoenix. And I think everybody knew that he was refer-

ring to patients on the electronic wait list and the schedule and appointment with primary care consults. So it was all conclusive.

So between those two sources, you have now found 83 patients, more than double what the original allegation was. So I have a couple of questions and then I will turn it over to Mr. Michaud.

But why was that information not included in the executive summary that VA, not you, VA leaked early, but you did not find room in it to include that we, quote, "pursued this allegation, but the whistleblower did not provide us with a list of 40 patient names," end quote?

Mr. GRIFFIN. I believe that you as the chairman received the same hotline that we did. It stated that there were 22 who had died on the electronic wait list and there were 18 who died on the consult list.

So in our pursuit of finding out what happened here, which was an exhaustive pursuit, which is still ongoing as you know because of the urology issues that we discovered, the obvious first question in our interview with Dr. Foote was give us the 40 names. We want to go after the records of these 40 people and ensure that we don't miss any of these 40 because it was so definitive.

Now, you were very careful in the hearing on April 9th to say potentially 40. As—as time passed, it became declarative by some that 40 died. Others said there were at least 40. So that spawned 800 media reports that 40 veterans died while waiting for care in Phoenix. That was the story as of the April 9th hearing.

To not address that with the amount of coverage and the millions of readers who would have read that would have been derelict on our part. So we didn't look at 40. We looked at 3,409 records to make sure we didn't miss any.

The CHAIRMAN. So it was important that you draw the fact that Dr. Foote did not provide you the 40 names? That was very important?

Mr. GRIFFIN. What was important was in the April 9th hearing in this room——

The CHAIRMAN. No. I am talking about the final report, not the April 9th hearing now. I am talking——

Mr. GRIFFIN. No, that—that was not—that was not something that was inserted in the final report. There were multiple drafts which is a very important point that doesn't seem to be getting any traction. We were asked to provide the first unaltered draft report and that's what we provided. That's the first time——

The CHAIRMAN. Let me draw——

Mr. GRIFFIN [continuing]. In 1,700 reports——

The CHAIRMAN. Let me draw a very clear distinction——

Mr. GRIFFIN [continuing]. We've been asked for one.

The CHAIRMAN. [continuing]. About what we asked for. Okay? Please provide committee with the original draft copy. All right? You may have thought that original meant the very first—that meant an unaltered copy. And I have an email that went to your staff that has original and then in parentheses beside it, it says unaltered. In other words, don't adulterate it in any way. We want the original draft. Again——

Mr. GRIFFIN. We received two requests from the committee, one from you and one from Chairman Coffman. One of them said un—

unaltered and the other said something different, but there wasn't any confusion that you wanted the very first initial draft report——

The CHAIRMAN. Well, let me read——

Mr. GRIFFIN [continuing]. Which is unknown——

The CHAIRMAN. Sir, let me read this email to you. You have gotten a third one that came from the staff director of the OIG, the O&I Subcommittee to Joanne Moffett.

Dear, Joanne, Chairman Miller would like to know if the OIG is going to provide the committee with a written copy of the original, paren, unaltered draft copy of the Phoenix report as first provided to VA. If so, when?

Mr. GRIFFIN. I guess I don't see what—what the difference is. You asked for the first initial draft report and we provided it.

The CHAIRMAN. Did you ever indicate to the committee or to the staff that there was more than one draft?

Mr. GRIFFIN. We did not. We provided what the—what the committee asked for and we also explained that in the last six years, no committee has ever requested a copy of our draft report because——

The CHAIRMAN. Well, shame on them, sir.

Mr. GRIFFIN. No. No. That's——

The CHAIRMAN. Shame on him.

Mr. GRIFFIN [continuing]. The way it is in the IG community.

The CHAIRMAN. Well, I am sorry, but——

Mr. GRIFFIN. A deliberative process——

The CHAIRMAN [continuing]. Here is the way it works here.

Mr. GRIFFIN. We're interested——

The CHAIRMAN. We want all of the information. We don't want you to use semantics about which copy of the draft we asked for. We asked for the draft that you gave to the VA so VA could make their determination as to whether or not that draft was factual or not. That was the intent. You knew that is what it was. Just wait a minute. It is my time, not yours.

Mr. GRIFFIN. Okay.

The CHAIRMAN. You knew what the request was. What we were trying to get is how did that get inserted from the draft to the final. And now we have testimony from Dr. Daigh that, in fact, they did not conclusively look at all the causes of death.

So I still make the statement, and then I am going to yield to Mr. Michaud, and I apologize to the Members, we have all got to be honest and open with each other about what is going on and whether or not any other committee has ever asked for a draft report, shame on them. Whether or not the OIG has ever sat at a table with anybody other than people from the OIG Office, tough. This committee is going to get the truth about all of the facts.

Mr. Michaud.

Mr. GRIFFIN. Mr. Michaud, may I respond to that? This is the crux of the whole allegation.

Mr. MICHAUD. Yes, if the gentleman would want to respond.

Mr. GRIFFIN. We were asked to provide the initial, because you didn't want one that had been through two or three iterations. You wanted the very first draft report. That was clear to us. You can deny that all you want, but——

The CHAIRMAN. Can you show me anywhere that it says we asked for the first draft report?

Mr. GRIFFIN. I would refer to the attachments to our report where all of this is spelled out in writing.

The CHAIRMAN. No. Can you tell me where we asked for the first draft report?

Mr. GRIFFIN. Do you have that email, David?

Let me find the email and—and I will respond to your question. The—the——

The CHAIRMAN. Mr. Michaud, you are now recognized.

Mr. GRIFFIN. It showed a—a lack of awareness——

The CHAIRMAN. Mr. Michaud is now recognized. You are out of order.

Mr. GRIFFIN. Do you want the truth?

The CHAIRMAN. Sir, you are out of order.

Mr. MICHAUD. Mr. Griffin, on the reports, if I understand you correctly, you did provide the first draft of the report, but there might have been other additional drafts out there?

Mr. GRIFFIN. That's correct.

Mr. MICHAUD. So the draft you provided was the first draft that was——

Mr. GRIFFIN. That was requested.

Mr. MICHAUD. Okay. But there was other drafts since the first one that came out; is that correct?

Mr. GRIFFIN. It was a draft. It is a deliberative process. In order for us to get concurrence from the department, we have to put a draft in front of them. If we had factual errors in that draft that they can convince us were factual errors, then it would be incumbent upon us to make whatever edits are required so that at the end of the process, the report in its final issuance speaks the truth on all issues.

Mr. MICHAUD. So when the IG does its reporting, you could conceivably get some information, whether it is from a whistleblower, whether it is from the department, that might not be factual and once you get information that you determined actually to be factual, that is when you change the report before it gets——

Mr. GRIFFIN. That's correct.

Mr. MICHAUD [continuing]. Issued to Congress?

Mr. GRIFFIN. And then there were some minimal changes. On one of the case reviews, we had the blood pressure numbers that were taken at two different times were reversed. To me, that is not a substantive change. Obviously we had them wrong. When—when they were reviewed, it was pointed out so we—we put them back the way they should have been. But that is not a substantive change.

Mr. MICHAUD. Okay. You mentioned that Dr. Foote mentioned an alleged 40 veterans. Did you ever receive the list of names of those that were on that list?

Mr. GRIFFIN. No. And I would refer you to the transcript of our interview which addresses that very clearly. It was even suggested that perhaps some of them might have been run over by a bus, that he did not know how—what the cause of death was.

Mr. MICHAUD. Okay. And he did not give you the definitive—I haven't read that transcript yet, but——

Mr. GRIFFIN. No. Understood. And I apologize for it arriving late, but it—it does need to be read by everybody who has a serious interest in this matter because it was a taped transcript of the interview.

Dr. FOOTE. Can I respond to that, please?

Mr. MICHAUD. No. I still got some other questions.

My other question is, of the 93 ongoing reviews, how many have been closed out and when do you believe that the rest will be completed, Mr. Griffin?

Mr. GRIFFIN. At this point, we have 12 of those that we have turned over to the department that I wouldn't say were closed because we would anticipate administrative action being taken. They're closed from the standpoint of we have completed the work that would have addressed the specific allegations that we were looking at.

Now, in the department in their proceedings to make determinations concerning administrative action, if they come across additional information that was not part of our focus, we—we may have to do additional work on those, but we have turned over 12 so far.

The others, they're not being worked with any intent of, okay, a week from tomorrow, the other 81 are going to be all published. We—we will turn these over to the department, those that do not get accepted for any criminal action, we will promptly turn those over to the department so they can take administrative action.

Mr. MICHAUD. Thank you.

Dr. Mitchell, in your testimony, you mentioned how good the Phoenix VA pain management team is, but that they lack the staff to supply the services to Phoenix veterans.

How did the Phoenix VA communicate their staffing needs to the director? Was it ever communicated and, if so, what was done, if anything?

Dr. MITCHELL. I don't have any direct knowledge of the communication between the pain management team and the senior administration to get additional staffing.

What I do have is direct knowledge from many, many providers who find their panels filled with patients who are on high-dose, long-term narcotics and they need—and the patients need additional close monitoring and follow-up.

What's happening is those providers don't have enough time to be able to get those patients in for sufficient appointments to be able to review that.

In addition, in the community, veterans or—I'm sorry—in the community, patients that are on long-term narcotics are referred to a pain management specialist to titrate the doses, provide ongoing education, and monitor for side effects. Unfortunately, the staffing at the Phoenix VA does not allow for that.

Mr. MICHAUD. Okay. Thank you.

I see my time has run out, Mr. Chairman.

The CHAIRMAN. Mr. Lamborn.

Mr. LAMBORN. Thank you, Mr. Chairman, and thank you for having this very important hearing.

Dr. Mitchell, briefly on page 15 of your written testimony, you pulled out case number 35 from the IG report as a special cir-

cumstance, and please explain why you did so in this particular case.

Dr. MITCHELL. I want to make it clear that I did not have access to the records that the OIG went through. However, anecdotally I was told that this was the same patient which I was familiar with and the details are the same with one glaring omission.

In the OIG report, the history starts with the patient presented with the ER—to the ER with his family seeking mental healthcare. He was evaluated. He declined admission. He was discharged home. He committed suicide the next day.

What was not in the report, and I believe this is the same case, if it's not, it should be reported anyway, his parents—he actually was having problems with depression. He called his parents. They brought him to the walk-in mental healthcare clinic. However, because he had not been enrolled in the Phoenix VA, he was diverted from there to the eligibility and enrollment clinic where apparently he waited for hours.

By the time he got enrolled in the system, he went back to mental health clinic and it was too late in the day for them—for him to be seen. So then he and his family were diverted to the ER where, again, they waited for a lengthy amount of time before they were seen by a psychiatric nurse to evaluate.

By that time, the people that were involved said the patient was very tired. He wanted to go home. He declined discharge. He was subsequently discharged at that point with—to have follow-up the next day in the same clinic that wouldn't see him earlier.

Mr. LAMBORN. Okay. Thank you for that clarification.

Mr. Griffin, when you shared your draft report with the VA before release, did VA propose any changes or ask any questions regarding what was in or was not in the report?

Mr. GRIFFIN. They did. They requested that we remove several of the case reviews that appear at the beginning of the report. We refused to remove them. They suggested that we flip flop the blood pressure numbers that were out of order. Of course, we changed that.

There were—there were two other minor things, one involving a date that was inconsequential to the outcome of the case review, so we fixed that. There were a couple of verb tenses changed and a recommendation that in no way whatsoever affected the intent of the recommendation. So those were changed.

None of the case reviews were substantively changed and the secretary agreed to implement all 24 of our recommendations.

Mr. LAMBORN. And how often do departments ask for changes before they are released to the public?

Mr. GRIFFIN. I suspect that there has probably never been a report where there wasn't some minor change not requested.

Mr. LAMBORN. Well, I want to talk more about the——

Mr. GRIFFIN. The reason being that they have to implement what we have found and what they are concurring with. And so they're going to scrutinize those things and make sure that—that they're in total agreement and they'll also look for those minuscule types—types of errors that will make the correct—the report more accurate.

Mr. LAMBORN. Well, when the language stating that you could not conclusively assert that there was a connection, do you know who leaked that to the press before the report was made public?

Mr. GRIFFIN. No, I have no idea who leaked that. That—that was—that was in the report. The report had a date certain for—for being published. It should not have been leaked, but the fact is it didn't change anything in the report.

Mr. LAMBORN. Was it someone in your office that leaked it?

Mr. GRIFFIN. Absolutely not.

Mr. LAMBORN. Okay. And I didn't think so.

The word conclusively is not a medical term of art as far as I know and as a lawyer, I know it is not a legal term of art.

On a scale of one to a hundred, where does that fall on the spectrum?

Mr. GRIFFIN. It's a reflection of the professional judgment of our board certified physicians. There have been a number of suggestions as to how we should do this. We received one from the committee saying we should unequivocally prove that delays caused deaths. We received that on April 9th.

What does unequivocally prove mean? We did a review of the quality of care that these 3,409 veterans received. That's what we do in all of our healthcare reviews. That's what their charter calls for when they were created.

Mr. LAMBORN. But there could be a connection less than conclusive.

Mr. GRIFFIN. I think in some of them, we—we said it might have improved the course. But to say definitely that this person would not have died if they had gotten in sooner was a bridge too far for our clinicians.

And I'll let Dr. Daigh expand on that.

Dr. DAIGH. The basic problem with this is that it's very difficult to know why somebody actually died. I'm not clairvoyant. I'd ask you to read also the testimony submitted by Dr. Davis where he supported the methodology we used in our report. That would be death certificates plus a review of the chart.

In the case that was discussed previously, case 29 where an individual died after failing to get an implantable heart device quickly, in that report, we said, and I'll read exactly what we said, we indicated that—oh, doggone it—we indicated that—that he should have—he should have gotten the device more timely. He died. I don't know exactly why he died.

You'd like to think that he died because he had an arrhythmia to his heart and that if that device had worked, maybe it would have saved his life. But I don't know that that's why he died. There are circumstances around the weekend of his death that are not included in this report.

And the reason that he came to our attention is that he was on a wait list for endocrine clinic. He wasn't on a wait list for cardiology clinic. Secondly, he's not in the group of patients initially where we culled those who were on a wait list to receive delayed care. He's in the list of patients who we said got substandard care, who—who in reviewing these cases, we found cases where the care did not meet veterans' quality of care.

So this gentleman was delayed in getting care between Phoenix and Tucson. So he's in the part of the draft where I think he belongs. I cannot assert why he died and that's why we had to——

Mr. LAMBORN. Okay, Doctor, thank you. My time is way over.

I yield back.

The CHAIRMAN. Mr. Takano.

Mr. TAKANO. Thank you, Mr. Chairman.

Thank you to all the witnesses who are appearing before the committee today.

Mr. Griffin, I did read through much of the material last night. I have to say I am trying to understand what the controversy is. I understand a charge has been made by the majority impugning your integrity. I understand them to mean that you were forced to change language or were persuaded to change language. I think that is the heart of the allegation.

Could you help me understand from your point of view what is the charge because I think the public needs to understand that and what is your response?

Mr. GRIFFIN. My response is there is a lack of understanding of the processing of draft reports. And it's understandable because it's the first time anyone has gotten one.

When we send a initial draft report over there, that does not mean that my senior staff and others—other members of our team aren't continuing to review that document and make sure that we've got it correct.

The fact that it went to the department without that statement isn't proof of anything. It's an ongoing process until the last day when we sign out that final report. And over the course of five different drafts, there were minor changes made for purposes of clarity.

The minute that the draft report came up here and the reason that you don't put draft reports out is because they're subject to interpretation and they're not final. And shortly after the draft came up here, it was reported in the press that here is proof that somebody in VA changed that. That's not proof. That just means that you don't understand the process.

And I can show, as I mentioned in my oral, six days before the initial draft was released, we were having discussions internally that if we don't declare that delay was the cause of death, we need to say so. Now, it took a couple more drafts before the causality line was included.

But I would point out on May 15th in a Senate hearing where the question of the original 17 names that we received came up, I was asked if we had a chance to review those. I said, yes, we had reviewed them and that being on a wait list for care does not demonstrate causality in a person's death.

That's three and a half months before this final report. So there should have been note taken that it does not demonstrate causality that you're waiting. And I think the last statement for the record that I would hope everybody will read because the witness won't be here, as Dr. Daigh already referred to, bears that out and bears out our methodology.

Someone might ask, well, why—why did you send it over there if it wasn't ready, because we have to put it in front of the depart-

ment. We knew the department had 24 recommendations that they had to write an acceptable response that convinced us that they got it and they were going to fix it. We knew they would need time to do that.

We had made a commitment to the Congress to publish that report in August. As a result, we had to—we had to cut off some work in order to be about the—the business of writing the report. And that's why Dr. Daigh's staff has got 3,526 urology patients that will be the subject of a future review.

Mr. TAKANO. Dr. Daigh, those 45 or some odd cases that were included, I wasn't able to read each in detail and, frankly, couldn't understand each one, but they did seem to me evidence of poor care, of bad continuity of care.

You said that those family members are being notified of what happened. Those family members can pursue litigation, I imagine, and the VA could be found culpable in some of those instances; is that right?

Dr. DAIGH. That's correct. So let me—let me offer this comment. The—the universe of patients that we set about to review in this review were primarily those patients culled from wait lists identified by whistleblowers, by our auditors, and by our healthcare inspectors.

So we were looking at people who were on a list and then did not get an appointment timely. That's the universe we're starting with. And, in fact, some of the cases from the NEAR list were part of what we were looking at.

If you weren't seen at the VA, then I couldn't see—I mean, my records don't allow me to take a look at whether you tried to get to the VA or didn't try to get to the VA. In our methodology section, we lay that out.

So from those cases, we were looking for people who had a delay in care and had a clinical impact on that delay. And—and those are the 28 cases that we identify in the front, six of whom had died.

To know why someone died is very difficult. And—and so when you get down to an individual commits suicide on a certain day after a certain event, you might like to say that event had something to do with the suicide or you might like to believe that—that but for going to the—the—the psychiatrist or the primary care doc, that event wouldn't have occurred.

But in—in the—in the world where we try to be able to prove and have data to support what we're saying, we have a hard time going there. So the—the—the—the second group of patients we report on are those that we found had a poor quality of care.

The other point I think is important to understand is that my charge in law, I think, is to respond to the Congress, to the secretary, and to the under secretary of Health and comment to them on the quality of medical care the VA provides.

So what I usually do is we—we look at an issue, and the issues are all different, and the question in this one was, we took to be, was there a direct relationship between a missed appointment and—and death. That's sort of what the media was talking about. We—we were forced to address that in some way.

And so once we determined that there was, in fact, patients that were—that had poor quality of care, we then always switch to,

well, what are the systemic issues at this VA that we can address to try to get VA to change their practices to make this never happen again.

When you go to the issue of exactly who committed the tort, exactly what did the—did the VA or the patient or the other hospital down the street or the nursing home, what exactly did they contribute to this death or this poor outcome, that's a matter for the courts and that's a matter for VA's internal processes.

So I get to the point of poor quality of care and then I always shift and focus on what can I do to work with VA to make sure we fix it. So I'll talk about—and—and, again, in the last written testimony, I outlined 10 or 12 or 15 reports where veterans were injured or harmed and we worked with VA as partners to try to get this fixed.

Mr. TAKANO. Thank you.

My time has run out. Thank you, Mr. Chairman, for indulging. Thank you.

The CHAIRMAN. Thank you.

Mr. Bilirakis.

Dr. MITCHEL.L Mr. Chairman.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

A question for Dr. Foote. In your testimony, you indicate that there may have been tampering of EWL software and that the numbers reported to central office differed from the real numbers of veterans waiting.

How is it that the EWL appointments could be overridden to zero out previous appointments and do you believe audit controls were deliberately disabled?

Dr. FOOTE. Yes. I think there was one of two methodologies used. Either they had two lists, one of which was reporting a number of 100 or 200, which the IG's graph showed that it was—it was a small number and not correct, or—and they had a second list where they disabled the reporting function or they went in and tampered with the re—with the reporting software so that it would not give an accurate number of, say, over 200.

Certainly the IG's data shows that from the inception of that list, it never gave the right number. Dr. Deering had said that the—the time that's broke out, that the waiting list time was 55 days. Well, on the actual non-reporting electronic waiting list, there were 14 to 16 hundred and the wait was six months. If you threw in the 3,500 that were scattered around on the scheduled appointment consults on loose paper, the wait was probably more on—on somewhere between one and a half to two years.

But I—I know I reported this to the IG. I've also reported this to the—to the FBI. And I know they're taking a look into it and hopefully they will be able to find the forensic computer evidence to support that claim.

Mr. BILIRAKIS. Thank you.

A question for Mr. Griffin. The language that was included in the OIG final report regarding the conclusive case of death has no relation at all to any accepted standard of measure in medicine.

As a matter of common sense, if VA doesn't schedule appointments early enough to treat a disease, it is highly likely that vet-

erans with potentially fatal conditions will needlessly suffer from conditions and possibly die.

The question, does that make sense to you and do you agree with that statement?

Dr. DAIGH. So I agree with your statement. The premise is that if you—if your care is delayed, then you should be—you—you are very likely going to be harmed. And—I—when we started this review, it seemed to me that that would be what we would find over and over and over again.

And we looked at these cases and we didn't find that, so we said, well, why didn't we find that. And I think there are two of Dr. Foote's cases in here where, in fact, you know, he can go home and say he saved a life. He found a patient that was in a waiting list who—or in a pile who had diabetes and another one that had critical heart care and he intervened to make sure that they lived.

It's also clear the veterans have access to other emergency rooms and other sources of care beyond the VA. So in retrospect thinking about this question, I think that people must have been extremely diligent at Phoenix where they knew the trains didn't run on time to try to make sure that vulnerable people got care.

I can only report the news. This is what I found.

Mr. BILIRAKIS. Okay. Let me ask you this. Was this measure applied when the OIG report reported that veterans died while waiting for care in South Carolina and Georgia?

Dr. DAIGH. We—again, I'll say that I normally go to the point where we determine that poor quality of care was provided. So the standard——

Mr. BILIRAKIS. But can you answer that question?

Dr. DAIGH. I'm sorry?

Mr. BILIRAKIS. Was this same measure applied when the OIG reported that veterans died while waiting for care in South Carolina or Georgia? What is your answer to that question?

Dr. DAIGH. It's—sir, it's usually a fact-based—it's usually a fact pattern-based decision on—on exactly what happened. I'm not sure exactly report—which report you're referring to. But, sir, it's usually—on each report, it's usually a different fact pattern. If we—if we determine that poor quality of care was provided, then we try to look at systemic issues and try to get VA to do the right thing with respect to quality of care.

Mr. BILIRAKIS. So the report discussing the delay in colonoscopies and those——

Dr. DAIGH. Oh, the Columbia? Okay. Yes, sir.

Mr. BILIRAKIS. Can you answer that question? Was the same standard applied——

Dr. DAIGH. In—in the Columbia case, it was our——

Mr. BILIRAKIS [continuing]. In the report?

Dr. DAIGH. I—I don't think the—I—I can't— the—the—the same standard wasn't applied because the fact pattern was entirely different. In Columbia, VA had found that they had delayed colonoscopies in a large population of veterans and as a result, as you would expect, a large number of veterans developed colon cancer that probably would have been prevented had the colonoscopy be—had been done. And VA admitted that some of those patients

had died and VA had already undertaken the process to notify those patients.

What my report was looking at was why did this happen, how is this possible. And what we determined was that VA does not have a way to ensure that nurses in—in clinics that need—if a nurse leaves a clinic and that job is critical to the performance of that clinic, refilling that position is given to a board within the hospital where administrators decide whether or not they're going to fill the nurse position or a teaching position or a research position.

So, again, we focused on what can VA do to make sure this doesn't happen. And so, yes, the same standard wasn't applied because the fact patterns were quite different.

Mr. BILIRAKIS. All right. Thank you.

Thank you, Mr. Chairman. I yield back.

The Clerk. Mr. Chairman, if——

The CHAIRMAN. I apologize. We have had a vote called and I would like Ms. Titus to have an opportunity to ask her questions before we recess to go to the vote.

Ms. Titus, you are recognized.

Ms. TITUS. Thank you, Mr. Chairman.

Mr. Griffin, like has been mentioned before and many of my colleagues, I am eagerly awaiting the results of the investigations at the other VHA facilities.

Southern Nevada is home to the newest VA hospital and many people think it is the best. It is state of the art. And we also have a large medical system there.

Now, I have been asked by a number of my constituents are the same problems happening here as in Phoenix because once you hear something like that, then, of course, it makes you worry and begin to think that there are problems.

I have talked to Isabel Duff once a week practically to be reassured that they aren't, but still I want to encourage you to finish up because not only do we want to solve any problems you might find, but I think that is a big part of restoring trust in the VA is to get that done and move on with it.

Also, you put forth 24 recommendations and as I look at them, I think there are 11 that relate specifically to Phoenix which that is important, but the rest of them look at the systemic problems.

Now, you have given those to the VA, said you recommend that they do this. This is a big dose, a large order that you are calling for.

Are you confident that the VA has the facilities, the means, the intent, the ability to carry out those recommendations and solve these problems so this does not happen again?

Mr. GRIFFIN. I would agree with your assessment that at present, they don't have the facilities. I think VA would be the first to admit that they need additional clinical space. They need additional clinicians. They need a new scheduling process. They need a methodology by which they can remotely monitor what wait times are in Las Vegas or any—any other place in the country where they have a medical center.

I think they're aware of all those things and I believe the new secretary and—and his team that he's assembling are—are dead serious about addressing those things. We do follow-up on our

recommendations. We have suspense dates for when things are supposed to be completed and we certainly will follow-up very aggressively on these 24 recommendations.

And we also have already had some initial internal discussions about how we might scope a future project to go out and verify that, in fact, everything is working according to the plan.

Ms. TITUS. That is good. You don't want to make recommendations that just sit on the shelf——

Mr. GRIFFIN. No.

Ms. TITUS [continuing]. Just for the sake of it.

Mr. GRIFFIN. We—we follow-up on those on a quarterly basis.

Ms. TITUS. I share your enthusiasm for the new secretary and I believe he is committed to both changing the attitude of the VA and making these specific reforms.

Do you think the bill that we just passed, the compromise bill, will be useful in addressing some of these 24 recommendations?

Mr. GRIFFIN. I'm afraid I'm not totally versed on the bill. I know there have been a number of legislative changes made in order to assist the department in accomplishing their mission. But I'd like to take that for the record, if I may.

Ms. TITUS. All right. Thank you.

Mr. GRIFFIN. Thank you.

Ms. TITUS. I will yield back, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Members, we do need to pause. I apologize to the witnesses. We think it may be about 30 minutes for us to go and do that. We will give you a heads up when we are going to start back.

And this hearing is in recess until immediately following the third vote.

[Recess.]

The CHAIRMAN. Thank you, everybody, for rejoining us. Again, I apologize for the delay.

Mr. Griffin, I would ask a couple of things. We have got other Members that are coming back. You asked that we put Dr. Foote's testimony from his deposition into the record. We did so without unanimous consent. We have not had an opportunity to review it. I see where you have done some redactions.

We have made an agreement that we would like to not enter it into the record until we have had an opportunity in a bipartisan way to look at any other information that may need to be redacted. I don't mind even sharing it back with you, so that we are not putting something into the record that could release personally identifiable information or illnesses or diseases or anything of that nature.

Is that okay with you?

Mr. GRIFFIN. That's fine. The—the redactions that you see are ones that were done by our privacy officer to make sure that—that we didn't have any names in there that should not have been there, but better to—to double check. That's fine.

The CHAIRMAN. Yeah. Because we hadn't had a chance to look at it prior to introducing it into the record, we have agreed in a bipartisan fashion, both of counsels have come together and said we will agree to the redactions and don't mind at all sharing it back with you.

Well, now that Ms. Kirkpatrick has returned, I would like to go ahead and yield the floor to you for your questions. So, Ms. Kirkpatrick, you are recognized.

Ms. KIRKPATRICK. Thank you, Mr. Chairman.

You know, Dr. Daigh, you brought up an interesting point and that is that there is a criminal process and there is a civil process if, in fact, causation is found because of deaths as a result of the wait times.

And is it your understanding that there is now currently an ongoing criminal investigation by the Arizona attorney general, the FBI, and the Department of Justice?

Mr. GRIFFIN. There is an ongoing criminal investigation but doesn't——

Ms. KIRKPATRICK. To your——

Mr. GRIFFIN. It involves the criminal investigators from the IG's Office. It involves the FBI. It involves the U.S. Attorney's Office in Phoenix.

Ms. KIRKPATRICK. So there is a process if in case causation is found?

Mr. GRIFFIN. Absolutely.

Ms. KIRKPATRICK. And to your——

Mr. GRIFFIN. If criminal behavior is—is determined to have occurred.

Ms. KIRKPATRICK. Yes.

Mr. GRIFFIN. Right.

Ms. KIRKPATRICK. And to your knowledge, you mentioned the Federal Tort Claims Act, are you aware of any cases that have been filed under the Federal Tort Claims Act as a result of deaths because of wait times?

Mr. GRIFFIN. I'm not aware of any, but that—that doesn't mean that there might not have been one. We checked on the 45 case reviews and we didn't find any filed on any of those 45.

Ms. KIRKPATRICK. Thank you.

Dr. Foote and Dr. Mitchell, I want to thank you for being here and for coming forward.

And I have expressed to you in the past that I appreciate your courage because all of us on this committee really are united with you in our care for veterans and making sure that they get the medical care and access to that care that they really care about.

And that is why I introduced the Whistleblower Protection Act. I wish that had been in place for you, but hopefully that will make things better for future whistleblowers. And part of that is a national hotline that patients and workers within the VA system can call and that information would go directly to the secretary in hopes that there wouldn't be any kind of retaliation.

But as I mentioned, this committee really is committed to access to care for our veterans. And, as you know, there was a bipartisan, bicameral Conference Committee that was appointed in the summer. We met together and we passed the Veterans Access, Choice, and Accountability Act of 2014.

And one of the primary pieces of that is a new choice card that will allow veterans who live more than 40 miles from a VA facility or have had to wait more than 30 days to schedule an appointment to actually go to a local provider.

And, Dr. Mitchell, I was concerned when you said that you didn't know if some of these people who were on the wait list knew that they had a choice to go to an outside provider.

Do you think the use of a choice card, which is going to go out in November to our veterans, giving them that option will help improve that?

Dr. MITCHELL. Thank you.

To clarify what I said, they had the option of walking into a VA primary care clinic to get care. At this point, if they were not enrolled in the VA, the VA would not pay for their care anywhere else. I think the idea of getting care access is wonderful.

What the IG said earlier was that, well, the veterans had a choice. They could go to an ER, a hospital, or a private doctor. They don't have a choice. Many Americans don't have insurance. If they get sick, they opt not to go to a physician. I don't know about the other members here, but, frankly, I would have a hard time paying for the cost of hospitalization or ER visit.

Many veterans will let their chronic diseases get worse. As evidenced in two cases, they kept going to the ER because that was the only way to get their severely worsening symptoms taken care of. That's the equivalent of only putting out the fire but never doing anything to prevent the fire from starting.

Ms. KIRKPATRICK. Well, I appreciate that. And our hope is that with the choice card that will make a difference, especially the veterans in my rural area who many of them are 40 miles away from a facility. They will be able to go directly to a local community.

And as you know, I have 12 tribes and 25 percent of my district is Native American. They will be able to go to their local Indian health services facility to get their veterans' care. So a huge piece of the reform act was encouraging a partnership between the VA and the Indian health services.

So, again, I thank you for your testimony, for helping to guide this committee to do some meaningful reform. And we will keep an eye on it.

I yield back my time.

The CHAIRMAN. Thank you very much.

Mr. Coffman.

Mr. COFFMAN. Thank you, Mr. Chairman.

Mr. Griffin, will you provide us with all emails, draft discussions, and comments provided by VA with regard to this report?

Mr. GRIFFIN. I can provide the IG emails. They will be reviewed by our privacy officer to make sure no one's identity is, you know, left in there that shouldn't be and we'll provide them.

Mr. COFFMAN. Mr. Griffin, as you are aware, the Department of Justice has already declined to prosecute 17 cases of possible criminal violations by VA employees that your office has referred to them.

What are some of the reasons the Department of Justice has provided for not wanting to prosecute?

Mr. GRIFFIN. Some of the reasons include that there—it was not determined that criminal behavior occurred. In some of the cases, they had more rigorous prosecutive standards for the cases that would rise to the level of getting prosecution as opposed to administrative action. In some of them, the fact that someone manipulated

the data, but there wasn't proof of a death as a result caused them not to prosecute.

Some of them said this has been a systemic problem in the department for a number of years that has been allowed to perpetuate itself and the ability to demonstrate that someone knowingly and willingly committed a criminal offense was too difficult.

Mr. COFFMAN. Were you surprised at that? Were you surprised at their response?

Mr. GRIFFIN. Well, I think that we work with these prosecutors every day.

Mr. COFFMAN. Yes.

Mr. GRIFFIN. Last year, we arrested over 500 individuals. We arrested 94 employees last year. So we're aware that they can't prosecute every case that they get. And, frankly, our investigators would like every case that they investigate to be prosecuted, but that's not the real world based on—on the demands on the Department of Justice and the court system, et cetera. So determinations are made by the Department of Justice in that respect and—and we have to live them.

Mr. COFFMAN. And let me just say I passed an amendment on an appropriations bill to put more money into the line item for the Department of Justice for the specific purpose of prosecuting these cases.

Don't you think, though, when you talk about systemic that there was a culture of corruption and maybe the fact that it was a culture of corruption versus an individual case, then I guess it was okay?

But let me ask you this then. But when somebody does something, manipulates records for the purpose of financial gain, isn't that a criminal offense of itself? Shouldn't there be an example set by somebody being prosecuted somewhere in the system?

Mr. GRIFFIN. I agree. And I am not saying there will not be, either. There have not been any at this point. You would expect that the cases with the least amount of evidence and the last amount of manipulation, if you will, or co-conspiracy would be the ones that would be set aside earliest. Because the additional cases will require more work. We are working feverishly on those cases because we know it is important to get through all 93 of them. And as we finish them if there will not be criminal prosecution I know the department is anxious to get those reports so they can take appropriate administrative action.

Mr. COFFMAN. And Dr. Foote and Dr. Mitchell, I just have a tiny bit of time left. Tell me, are you surprised that there were not criminal prosecutions, Dr. Foote?

Dr. FOOTE. Not at this point because I think the FBI is still investigating.

Mr. COFFMAN. Okay. Dr. Mitchell?

Dr. MITCHELL. I am not surprised because there is still retaliation against whistleblowers. There would be no reason to prosecute the people who are perpetrating it.

Mr. COFFMAN. And Mr. Griffin, it does seem like the Department of Justice is looking the other way because obviously this situation is embarrassing to the administration. With that, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you. Mr. Walz, you are recognized.

Mr. WALZ. Well, thank you, Mr. Chairman. I want to thank all of you for your work towards veterans and that is what we are here to get. The situation in Phoenix and elsewhere that provided even one veteran substandard care is simply unacceptable. And I would like to go back, I have a long history with the OIG's Office. I know as someone myself, I counted in my unit heavily on the IG to provide another set of eyes to provide that unvarnished view of what was going on. So let us be very clear, what is being implied is that the integrity of this office was influenced by the VA. So I am going to ask very clearly, Mr. Griffin. Did anyone at the VA ask you to change the report to make it look better in their stead?

Mr. GRIFFIN. No.

Mr. WALZ. Is it normal standard operating procedure for multiple drafts of a report to be done?

Mr. GRIFFIN. It is, especially a report of 170 pages with 24 recommendations.

Mr. WALZ. Has there been a case before where your methodology has been questioned to the point where you were called in front of Congress to defend the methodology, not the results of the report?

Mr. GRIFFIN. No.

Mr. WALZ. This is the first time?

Mr. GRIFFIN. That is correct.

Mr. WALZ. And is it your understanding and again to get it, that it is predicated on the interpretation if you were asked for the original draft?

Mr. GRIFFIN. That is correct.

Mr. WALZ. Okay. With that being said, I want to be very clear. The report you issued is very damning to the VA.

Mr. GRIFFIN. It is.

Mr. WALZ. And there are many things that they fell down on. And the Department of Justice, and making sure that Dr. Foote and Dr. Mitchell and everyone else who is willing to correct things, there has to be a route and an avenue that people are made whole and that people are held accountable. And from my understanding, that is in the process. That the FBI and the Department of Justice are looking at it. Is that correct, Dr. Griffin?

Mr. GRIFFIN. The investigation is ongoing in Phoenix and other places. But we also in our very first recommendation in that report referred the name of the 45 veterans in our case reviews to the department for them to conduct appropriate reviews to determine if there was medical negligence and if there ought to be redress to the veteran or his family——

Mr. WALZ. Does——

Mr. GRIFFIN [continuing]. For receiving poor care.

Mr. WALZ. Does the VA OIG prosecute cases?

Mr. GRIFFIN. We investigate cases. We take them to the prosecutors in DoJ, or in some instances in state court if we cannot get traction on a federal violation.

Mr. WALZ. Okay. Does this report and the way it was handled strike you, Mr. Griffin, and if I am right how long have you been with the OIG?

Mr. GRIFFIN. About thirteen and a half years total.

Mr. WALZ. How many investigations have you been a part of roughly?

Mr. GRIFFIN. Well we have done about 520 arrests every year for the last six years. I, that is a number that is handy to me. But that is about an average year for us.

Mr. WALZ. And the methodology, the folks who work for you, your investigators and how you wrote the report, is there anything strikingly different about this one than any of those previous ones you have done?

Mr. GRIFFIN. This was a very large undertaking and it was a combination of our criminal investigators, who are the same job series as FBI agents, Secret Service agents, etcetera. But it was a joint project where Dr. Daigh's people had ownership of the medical care and the case reviews. Linda Halliday's staff, the audit staff, had the responsibility to try and identify all of these people who were not on an electronic wait list through a number of different sources. So her staff did that. So to try and pull the three different disciplines together and get everybody on the same page as far as what makes sense, I mean, there might be some language that makes sense to David that might not make sense to——

Mr. WALZ. Because, and I would argue that it makes sense to Dr. Foote and Dr. Mitchell.

Mr. GRIFFIN. Sure.

Mr. WALZ. That is coming out. Because there is still obviously the belief that we have not gotten to the bottom of this. That we have not gotten everything that has been done, or there has not been held accountability. With that being said I want to use my remaining time that that will still be investigated. My immediate concern right now is on those 24 recommendations. Do you feel in your professional judgment are they moving in the proper direction? Because you have had people come here and testify before that VA did not implement your recommendations and you had to come back again. Do you feel at this point, and I know it is early——

Mr. GRIFFIN. It is early. It is less than a month since the final report was issued. But I can tell you this. A lot of the wait times issues were previously identified in our interim report.

Mr. WALZ. Correct.

Mr. GRIFFIN. And I know that the department started addressing those immediately. In the updated report when we identified an additional 1,800 veterans that were not on a list that were in a drawer or were just not properly being managed, we immediately gave those 1,800 names to the people in Phoenix so they could make sure those veterans who had not gotten care got it as quickly as possible.

Mr. WALZ. Can I ask one final quick one? Just a yes or no from each of you. And I know this is very subjective but you are at the heart of this matter and you have a better insight than anyone. Does it feel like cultural changes are beginning to change to hold accountability, in your opinion?

Mr. GRIFFIN. I think the change will come as we complete more investigations and people realize that there is a price to be paid.

Mr. WALZ. Dr. Foote and Dr. Mitchell?

Dr. FOOTE. I would say asking for my testimony to be made public, I would not agree with that statement. I would say no.

Mr. WALZ. Okay.

Dr. MITCHELL. I would say no. There is lots of investigations but there has been no substantive change.

Mr. WALZ. Very good. I yield back. Thank you, Chairman.

The CHAIRMAN. Thank you very much. Ms. Walorski?

Mrs. WALORSKI. Thank you, Mr. Chairman. Dr. Daigh, you had said earlier today I believe to Chairman Miller that you did not conclusively examine all the medical records to determine if patient deaths were related to delays in care. Yet in the report your colleagues released it said, "The IG's final report in August concluded that it could not conclusively assert that long wait times caused the deaths of these veterans." Can you explain to me and to the families who are watching today who have been going through this, especially if they have lost loved ones, how can the VA emphatically say to us that you can determine no link between wait times and deaths if you did not examine all the records? Dr. *Daigh.* So let me clarify. We examined 3,409, 3,409 records. To the chairman's point, we did not examine all the records of patients on the near list, that would be people who said they wanted care at VA, if they never actually made it through the maze and got an appointment. So if there was no record for me to review, given that the electronic medical record was our main source, then I could not review those cases.

All of the cases that we were able to review came from a whole variety of lists, most of which had to do with waiting lists that we found at Phoenix. So in those cases we did I think very thoroughly review those cases. And in those cases where we determined that there was harm, the delayed care caused harm, we published those. And in those cases where we found improper care, we published those. So we have 28 cases that we thought people were on a waiting list and as a result of being on a waiting list, they were harmed. We have an additional 17 cases where we thought the standard of care was not met, that, and so we published those cases.

I think that I have, I am not trying to say to people who could not get there, who through frustration could not make it through the barriers, I am not trying to excuse anything at the VA. I am only trying to answer a fact. On these people, on the cases we looked at, did we see a significant impact on their care because they were on a waiting list? And that is, that is what we found and that is what we published.

I further say that I do not believe that our review necessarily needs to be determinative. In the sense that I put the scenarios out there hoping the citizens would read these cases and would understand the complexity that these veterans present, and understand the difficulty that they have, understand the fragility of these cases. So that when they do not get care in a timely fashion, horrible things are likely to happen. And each person then can read these cases and they can decide whether a person who might have unfortunately committed suicide, do they think that was related to timeliness? They can make their own decision on that point. So I offered the opinion of my office, which has the ability to see lots

of data that is not in these summaries intentionally. A lot of the data is unnecessary for the basic fact pattern. These families have a right to privacy, so we try to be very careful about what we decide to publish with respect to facts to a case. So to the issue that people would like more data about these cases, I understand it. But I think, I think that the VA needs to ensure that veterans have access to care that is done appropriately, that the trains run on time, and in that way the VA can deliver proper care.

Mrs. WALORSKI. I am just curious. If you had a chance to go back and reinvestigate these cases and the procedure, would you do it differently today?

Dr. DAIGH. No, I, I would not. I think the way we did it is the way we have done this for many, many years. I think it is over thorough and I think it produces a fair result. What I would wish we had, which I wish we had not been tied to was this issue of timeliness. Trying to explain the impact of being on a wait list with quality care, that is, I mean, that is a totally made up standard based on the circumstances of the complaint at this case. If I could have picked something different to look at we would have thoughtfully come up with a different test. But that is the test we were presented with and so that is the test we had to try to address.

Mrs. WALORSKI. Thank you. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you very much. Ms. Brownley.

Ms. BROWNLEY. Thank you, Mr. Chairman. Mr. Griffin, is, do you know if there is a parallel FBI investigation going on at this particular?

Mr. GRIFFIN. There is a joint investigation involving my people and the FBI.

Ms. BROWNLEY. Investigating the same issues? Asking the same questions?

Mr. GRIFFIN. They are doing it together. If there is an interview happening there is an FBI presence and there is an OIG criminal investigator present.

Ms. BROWNLEY. Thank you. And Mr. Griffin, you in your answering a member's question when, related to the closing out of 12 cases and still 93 ongoing, you mentioned something about they were closed out because they met the criteria and the, the questions were answered. But you talked about additional information that was not necessarily related that you have culled together. Can you talk a little bit about the additional information? Is there something, can you give me some examples, and is there something——

Mr. GRIFFIN. Let me clarify that point for you. When we did some of our 93 investigations, the 12 that we have given to the department, we, we did not do a Phoenix level review of every one of those facilities. That would take ten years. What we did look at is where we received allegations, either through our hotline or from any number of other sources of a specific infraction going on there. And in some instances with more specific language than others. Okay? So we investigate those. If it, if the result does not rise to the level of the U.S. Attorney's Office in that district to approve criminal prosecution, that investigative package within the scope of the review that was done is given to the department. It is incum-

bent upon the department, it is their job to review that information and say, okay, maybe someone decided this does not rise to the level of criminal prosecution, however we think disciplinary action, which can range from counseling to firing, needs to be taken in this case.

So in order to prove that, which they will have to do, they will look at the piece of the investigation we did. They may determine that they need to go interview somebody else for whatever reason to support their administrative action. And if that were to result in some new information that we were not aware of, it could cause us to reopen our investigation. But it is, it is up to the department to take those administrative actions. That is why when there is no criminal prosecution forthcoming on a specific case we hand over our reports and transcripts, etcetera, to the VA and they can take administrative action based on those in large measure.

Ms. BROWNLEY. So there is not additional information or a list of additional information that was uncovered that has not——

Mr. GRIFFIN. No, we——

Ms. BROWNLEY [continuing]. Or will be investigated?

Mr. GRIFFIN. Not during our investigation. I am just saying that if, if in putting together their review for purposes of administrative action, if somehow they come up with some information that was not——

Ms. BROWNLEY. They being the department?

Mr. GRIFFIN. They the department, who have to propose the action whether it be removal or something less than that. It could cause us to say we are going to go back and look into this further. But that is just the way the process is.

Ms. BROWNLEY. I wanted to follow up I think on Ms. Titus' questioning and just ask, you know, very, very specifically if you believe that there are adequate resources to continue and to complete the ongoing investigations at the remaining sites?

Mr. GRIFFIN. I think that some of those investigations are of much more narrow scope than the magnitude of the review we are doing in Phoenix. We are progressing on the remaining 81. Every week there is another handful that we are able to bring to closure. So, you know, the answer is yes. We have the resources. But I must say that this is not the only investigation that our people are involved with. Since January the number of threat cases that have come to us on VA facilities, the number of assault cases. We have made 86 drug arrests since January 1. So some of these matters that are already in the prosecutive mode, I mean we prosecuted a medical center director for 64 counts of corruption. And we certainly could not drop that case in order to, you know, take on a new case when it is going through the judicial process.

Ms. BROWNLEY. Thank you, and I yield back.

The CHAIRMAN. Dr. Daigh, there were 293 deaths, is that correct?

Dr. DAIGH. There were 293 deaths that we reviewed, that is correct.

The CHAIRMAN. How many of those were cross referenced with medical documents?

Dr. DAIGH. All of them.

The CHAIRMAN. No, I think there were 28 that were on the near list that you, I am, I am trying, again, I am honestly trying to learn, Mr. Griffin. And you have educated at least me as the chairman today on some things. I am, you, Dr. Daigh, you said because they were on the near list they were not in the system so there was no medical record for you to review and you were not able to do that. So you——

Dr. DAIGH. So let me, let me please clarify. The near list included a large number of patients. Of the patients that we reviewed from the near list we would not be able to review a patient if we did not have a medical record. So if you were on the near list, we do not have a record, then we excluded you from the review. So in our methodology section, we can only look at cases that actually come to the VA.

The CHAIRMAN. And, and I understand.

Dr. DAIGH. Yes.

The CHAIRMAN. But how can you, and I keep going back to this, how can you say you conclusively were able to say these individuals did not get timely care? They are now dead.

Dr. DAIGH. I am talking about the cases that we were able to review.

The CHAIRMAN. I understand that. But there were cases that you have just said that you cannot review and I, that is, all I am trying to figure out is there are cases that were part of this investigation that you apparently could not review them because there was no medical record for you to look at. And so my question is, again, of the 293 deaths, did every one of them get cross referenced with some type of medical record?

Dr. DAIGH. So the total number of people on the near list is a big number. The total——

The CHAIRMAN. [continuing]. I am sorry, the 293 deaths——

Dr. DAIGH. Yes, but what I am trying, what I am trying, I am just trying to be clear, sir.

The CHAIRMAN. Okay.

Dr. DAIGH. The 293 deaths were all among patients, from whatever list they were on, that had a medical record that we could review. So I am going to agree with you. There would be people who would be on a near list, who did not have a medical record, who we could not review. And therefore they were not part of the chart because it is not possible for me to review them. So all of the deaths, there were 293, we reviewed intensively.

Now the 293 number is a data point. The 293 number is from the 3,409 patients, 293 were dead. But that number is a number that has limited meaning in the sense that we, it is drawn from a population that you do not know the disease burden of. And so I cannot tell you whether 293 is too high or too low. Because the reason for death could be normal, normal causes.

The CHAIRMAN. I understand. I apologize, but I am still trying to find out. Because in a staff briefing staff was told that in some instances all that could be done was a match of social security numbers, then looking at a death list. And so there was no way for some of those individuals to be cross-referenced with a medical record. That is correct, is it not?

Dr. DAIGH. No, I think that that would be a misunderstanding of what was said. We, I would not purport to comment on cases that we had not been able to review the record for. That——

The CHAIRMAN. But they were on the lists, correct?

Dr. DAIGH. Well so in, again, in our methodology section we said we excluded—so I realize we are all talking subtleties here and I am not, I am really trying to be clear. I cannot report on cases who I have no information of. So——

The CHAIRMAN. And that, and I concur. And I think that is where the crossed wires are coming from. Because it is very hard for me to accept a statement in a document, as we have been discussing, if you have not been able to look at every single medical record, and thank you very much for clarifying that.

Mr. Huelskamp.

Dr. HUELSKAMP. Thank you, Mr. Chairman. I appreciate that line of questions because I was also, still am confused of where you were able to identify the, excuse me, 3,409 veterans, those were the number of the cases that you reviewed?

Dr. DAIGH. Yes, sir.

Dr. HUELSKAMP. And you had medical records for all those cases?

Dr. DAIGH. Yes, sir.

Dr. HUELSKAMP. Okay. But in pages 34 and on in the report you identify numerous other categories of veterans that would total well over 9,000 that are on, either not on electronic waiting lists, or on the electronic waiting list, or on the near list, or 600 printouts, or schedule and appointment consults, a backlog redistribution. How did you decide the 9,121 gets reduced to 3,409?

Dr. DAIGH. Well the report talks about in Phoenix there were many lists. And the report talks about lists from different sources and different points in time. So if you are talking about cases that were part of the Appendix, which were the VA, were VA's cleanup action, those cases were not part of the, most, by, by, by, by most, most of those cases were not part of——

Dr. HUELSKAMP. But excuse me, my, this is, I do not believe it is in the Appendix. It is page 34, question two identifies again 9,121 veterans. And again, they may not be cumulative. My question is how did you decide not to look at 5,600-and-some cases of veterans, you decided not to review their case?

Dr. DAIGH. Well we looked at those lists that were collected during the time frame of when we started our review up until about June 1. And I would, I would have to go through and work through the data set we have of the, of the actually 3,562 names on a list, which distilled to 3,409 uniques, individuals, of which 293 had died and of which 743 had a physician review them. So I would have——

Dr. HUELSKAMP. If they were on the electronic waiting list did you look at them and review their cases or not?

Dr. DAIGH. We did. So everywhere, everybody that we were able to determine was on any of these waiting lists of any variety described in this report——

Dr. HUELSKAMP. But I just gave you another 5,600 that you put in the report. I am trying to figure out why you did not look at, say, the, those on the near list had 3,500. Did you not look at any on the near list?

Dr. DAIGH. If you were on the near list and you asked for veteran, to get into the VA system, but you did not ever, you never made it through the wickets and you never got care, you would not——

Dr. HUELSKAMP. So if you died waiting for care because there was a failure in the system they do not show up in your data as a death because of the system?

Dr. DAIGH. That is, that is correct. They——

Dr. HUELSKAMP. Wow.

Dr. DAIGH [continuing]. Would not have showed up——

Dr. HUELSKAMP. Is that not the crux of the problem? Thousands and thousands and thousands of veterans are waiting for care and your report says, well, we do not count them because they died before we got their records. And we are not going to go back and look at other sources.

Dr. DAIGH. I——

Dr. HUELSKAMP. That is what I am trying to figure out. Because you winnow it down to 9,121, and they may not all be uniques. And it is pretty unclear to me, and perhaps the rest of the committee, maybe they get that. If you could provide some information to the committee as a follow up of how you decided to exclude the 5,600. And that would be helpful as well. And I want to ask you one other question as well, Mr. Chairman. Mr. Griffin, the day before you released your final report to Congress a number of news outlets were carrying reports with headlines, because I know you look closely at headlines, you have counted all the news stories, and some of the headlines says, "No proof that delays caused patient deaths," "No links found between deaths and veterans care delays," and "No deaths related to long waits." Do you think these are accurate? Or are they misleading headlines?

Mr. GRIFFIN. I have seen plenty of misleading headlines in the last two weeks. Some of them directed at my organization.

Dr. HUELSKAMP. But the ones I read to you, Mr. Griffin.

Mr. GRIFFIN. Okay.

Dr. HUELSKAMP. The ones I read to you, are they misleading?

Mr. GRIFFIN. The ones, no. But that is part of the story here. If someone leaks something before the scheduled release date of our report, and if it quoted our report, it should not have been leaked but that does not mean it is not true.

Dr. HUELSKAMP. Have you ever seen a leak before? So is that report headline, is that misleading?

Mr. GRIFFIN. Could I, could you read it to me again?

Dr. HUELSKAMP. Yeah, absolutely. And I am sure you have seen it before. "No deaths related to long waits." No deaths. Is that misleading?

Mr. GRIFFIN. That is an accurate representation of our conclusion, that we could not——

Dr. HUELSKAMP. No deaths?

Mr. GRIFFIN [continuing]. We could not assert a cause of death being associated with the waiting times.

Dr. HUELSKAMP. How about no link?

Mr. GRIFFIN. Those are not my words, I, you know.

Dr. HUELSKAMP. But I am asking you for your thought on them. Because you were very worried about 800 headlines that you looked very closely at.

Mr. GRIFFIN. I am not worried about anything.

Dr. HUELSKAMP. Well actually——

Mr. GRIFFIN. I am just, that is just the reality that you could get out of Google to show the amount of coverage that was put on the statement that there were 40 dead and that there was no ifs, ands, or buts about it. That does not take a lot of research to find that, okay?

Dr. HUELSKAMP. Yes.

Mr. GRIFFIN. Okay. So——

Dr. HUELSKAMP. Yes. Well, thank you. I just, I still am not for sure if you, apparently those headlines are okay, then? They are not misleading?

Mr. GRIFFIN. I did not say they were okay.

Dr. HUELSKAMP. Well are they misleading?

Mr. GRIFFIN. I think headlines are sensational to get people to read a story. They——

Dr. HUELSKAMP. Well I think it is sensational that there is 5,600 veterans cases that apparently were not reviewed and that you have in the report. And so I look forward to the determination of why you decided not to review those cases. Because I fear there are more veterans that died——

Mr. GRIFFIN. I think as Dr. Daigh said there was nothing to review if they did not get in the door. He was reviewing medical records and if they did not get an appointment, they did not have any records to review.

Dr. HUELSKAMP. But when you said there was no causality and they fail to get in the door and die because we did not deliver care, I say that is causality and your statement would be misleading, then. I——

Mr. GRIFFIN. We do not know how they died or why, nor do you.

The CHAIRMAN. Mr. O'Rourke.

Mr. O'ROURKE. Thank you, Mr. Chairman. And I will say that Mr. Griffin and Dr. Daigh, I think by the criteria that you have described to us that you are using to reach your conclusions, I understand where you are coming from. And I think it is a rather narrow legalistic interpretation of the data, but I understand it and I think you have made that very clear today. And so I accept within those constraints what you have concluded. But common sense tells me, just from cases that I have seen in my district, that there is a cause and effect relationship between care that is delayed, that ends up being care that is denied, that ends up in veterans dying. And I have used this example before, with all due respect to the family, but they have shared their story with me and I think it is for a purpose.

You know, Nick D'Amico, who had been trying to get mental healthcare at the El Paso VHA was unable to for untreated PTSD. And after attending, after not being able to and attending one of my town halls where veteran after veteran stood up and said, "I also have not been able to get in," he was driving home and his mom related this story with me, to me, that he was driving home that night with her and said, you know, "Some of these guys are

much older than I am and have been trying for years to get in and cannot. I do not know what I have to look forward to." And she cited that lack of hope as one of the main reasons that he then took his life five days after that meeting. We know in this country 22 veterans a day sadly take their own lives. And I have got to think there is a connection between delayed, deferred, and ultimately denied care, and these very tragic instances of suicide.

Now I do not know if it meets the strict legal criteria that you are using. But it makes a lot of sense to me, and to draw that connection and that conclusion. And I think that is what is prompting so many of us to try to improve the level of access and the quality of care. And I do not think you would disagree with that. I mean, your conclusions here, you make some very bold statements. You talk about a breakdown of the ethics system within VHA, which I take to be a comment on the largest issue that I see that we have a problem with. Which is not funding and resources or number of doctors, but is the cultural aspect of VHA, the lack of accountability, a premium based on performance bonuses and not on excellence of care. Not on responsibility, not on patient outcomes for the veterans that purportedly the VHA is there to serve.

I looked at your recommendations related to ethics on page 74 of your report. They were pretty narrow. I think good recommendations all of them, but fairly narrow. Are there other recommendations I may have missed that more fundamentally address the issue of culture within VHA? And I would love to know what those are and how the Secretary, I will ask him when he is here, how he is going to respond to those recommendations. Mr. Griffin?

Mr. GRIFFIN. The original draft report had four or five recommendations speaking to ethics. They were very narrowly constructed so they were combined into one global ethics recommendation. The Secretary previously was the Chief Ethics Officer at P&G, he was the Chief Compliance Officer at P&G. I suspect that we are going to see ethics placed at a level where it should be. We did not find that in our review in Phoenix, when there was a request for an ethical review and not all of the recommendations were followed that were put forward by the person who submitted them. There was a reorganization in VHA which removed the Chief Medical Ethics Officer from the inner circle of the highest tier of management in VHA and was relegated to a lower level, which removed that person from a seat at the table with the most senior people. I suspect that we will see a change in that. And I think what had been ethics just from the medical ethics perspective is something that will be expanded beyond VHA to other areas in the department.

Mr. O'ROURKE. I, and I have not read every single page of this report, and I am currently reading it and I need to do that. But what I have not seen, and I have read through the ethics section of it, what I have not seen are some specific recommendations on accountability, on people losing their jobs. We have heard the most egregious instances of dereliction of duty, of abuse, of fraud, and later learn that those people are still on the job. I cannot argue with anything you said about the incoming Secretary, or new Secretary. I had a chance to meet with him yesterday and I am really looking forward to his leadership. But I think we need to institu-

tionalize these cultural changes. And you were asked a question earlier by one of my colleagues, anything in that July compromise bill that you think would help change the situation. I think the ability to fire senior executives, get the dead wood and the fraudulent actors out of the way quickly so that we can bring up those who are the best and brightest and have the outcome of the veteran first and foremost in mind is what we really need to do. And I am not seeing that still. And throughout the system, including in the part of the system where I have the honor of serving veterans there. I realize that I am out of time. I appreciate the chairman's indulgence, thank you.

The CHAIRMAN. Thank you. Dr. Roe.

Dr. ROE. I thank the chairman. I am going to approach this a little differently. And Dr. Daigh, and Dr. Foote, and Dr. Mitchell know what I will be talking about, and this is grand rounds. And for those of you who do not know, when you are in training you present cases to staff and they critique your care of those cases. And I had a chance to review many of these cases and to draw the conclusion, Dr. Daigh, that you did, and maybe it is the criteria as Mr. O'Rourke said, that it had no effect on the outcome of those patients is outrageous. I mean, you would have lost both limbs where I was if you had tried to convince a staff a member where I am, or me when I was a staff member.

And I think the question I posed to you in one of these cases if this were your family member, yours, just like case number 29 that had the congestive heart failure. If this was your dad there and would you be happy with the explanation you just gave of his death? And secondly, would you accept that? And my suspicion is no. Because you know that if your dad had gotten his allergy testing and an implantable defibrillator, the outcome may have been very different. That is why we put these devices in and prevent sudden cardiac death. And secondly of case number seven, this one the VA just got lucky on. I mean, a guy in his mid-sixties comes in to see a doctor with chest pain and has nothing done for seven months? I mean, all you can say is you got lucky. Because he very well could have died of coronary disease, which he had a bypass operation. But it was certainly nothing the VA did to help him prevent that. And one of the reasons, and I can assure you that in most private facilities if this guy had come in the emergency room like this he would have had a cath. Hypertension, mid-sixties, and chest pain, you cannot wave a redder flag than that. And what does this guy get? They control his blood pressure and send him out. And they are just really, really lucky.

Case 31, a man with an elevated PSA. I have a little sensitivity to that. I have had one elevated before. It is a little worrisome when you are a veteran with an elevated PSA. This, it looks to me like this veteran just sort of got ignored for a while. Now would he have died and you cannot say, I think you can say, and what I would like to do is to have these criteria, or have this looked at by the Institute of Medicine or some other outside source to see if they draw the same conclusions. Because I certainly do not draw the same conclusions that you did.

You are right. You cannot absolutely say that this veteran, missing this appointment or whatever. But it is the culture that I see.

I mean, right, you miss one appointment, that probably did not cause your death. I have got that. But the culture of, I just do not understand it, where you do not follow up. People drop through the cracks. CT scans reordered, nobody gives a follow up on these. And Dr. Foote, I want to stop because I am going to use all my time. But I want you to comment. You have been a clinical director for 19 years. Do you agree or disagree with what I just said?

Dr. FOOTE. Oh, absolutely. And my point was before about how the IG had somewhat downplayed the case. And let us talk about case seven. And what really happened in that case is quite different. And he had been waiting 12 months at the time, for an appointment with the VA, when he presented in January with the chest pain, having chest pain several times a week. All right? An EKG was done and the IG referred to it as an abnormality. The abnormality was Q waves in V1 through 3, suggestive of a prior anterior myocardial infarction——

Dr. ROE. Infarction, yes.

Dr. FOOTE [continuing]. In a patient having chest pain. All right? He was given an appointment in October from January. Only because my MAO spotted it in June when they gave us those appointments did I get him in sooner. At that point he was having daily chest pain and he now had Q waves in V1 through V4.

Dr. ROE. So he had unstable angina.

Dr. FOOTE. Right, absolutely. And an echocardiogram showed that he had an ejection fraction of 35 percent, 50 is normal, and he had anterior wall abnormalities. So my, my analysis of this case is that he had a heart attack in the 12 months while he was waiting. He further extended that, and fortunately, fortunately we were able to get him urgently cathed and bypassed. But, and he, so he is a guy that saved his life but lost 30 percent of his heart function. And the IG report referred to that as a favorable outcome.

Dr. ROE. Well I guess if you do not go to a funeral it is a favorable outcome. But I can tell you that, that was not, if that had been my family I would have been very, if it had been me, or if it had anybody sitting at that dais you would not have been happy with the care you got. And I went through case, I looked at this at one veteran at a time and evaluated it not as a system or whatever just how did that one veteran get their care, and would this care pass muster that we have to pass in the private sector to get paid by Medicare or anybody else. The answer is of course it would not. And I am embarrassed by this. I mean, when I read a lot of these cases it was embarrassing. Dr. Mitchell, would you like to comment?

Dr. MITCHELL. Yes, I would like to go on the record against the entire OIG. When you have a patient who is unstable psychiatry, who is verbalizing suicidal ideation, like in case number 39, if you discharge him home he will commit suicide unless something intervenes. In this case nothing did and he committed suicide.

For the gentleman in case number 40 he was demonstrating psychiatrically unstable behavior as an inpatient. The psychiatrist had the option to stop his discharge. If you discharge a psychiatrically unstable patient who has got a history of hurting himself, he has got a history of suicidal ideation, he will commit suicide. The only question that should be asked is when.

This is National Suicide Prevention Month. The VA has a wonderful program on the Power of One, which means that one person, one kind act, one question can stop a suicide. This gentleman should have had, both of these gentlemen should have had the Power of One, but One being the Department of the VA. This was totally inappropriate medical care for psychiatric patients. And on behalf of every mental health provider in the United States, I will say that if you discharge an unstable psychiatric patient who is verbalizing suicidal ideation, he will commit suicide unless something happens to intervene.

Dr. ROE. I thank the chairman. I yield back.

The CHAIRMAN. Ms. Brown.

Ms. BROWN. Thank you, Mr. Chairman. Mr. Griffin, in my 22 years on this committee I have never heard anything from the Inspector General that would make me believe that the Office of the Inspector General has worked with the VA to soften the findings. Nothing. Nothing there. But I think it seems to me that people think that because an allegation is a criminal offense and therefore should be fired without any due process. Can you explain that to me? And I am thinking about the 93 ongoing review cases.

Mr. GRIFFIN. Right.

Ms. BROWN. Yes.

Mr. GRIFFIN. We receive many, many allegations. In the last 12 months we got 34,000 allegations through our hotline, okay? That is why we have investigators and auditors and doctors and other clinicians. So when we get an allegation if we have the resources available and it rises to a level where we feel compelled to take it, that is why we go out and do our reviews and either conclude yes, this allegation is correct, or no, it is not. But until such time as we have accomplished that, an allegation is an allegation.

Ms. BROWN. It seems as if everybody seems to think that every veteran is eligible to participate in the VA. And that is not accurate. I know that the former Secretary opened it up to millions of additional veterans. Can you explain that? In other words, everyone that was in the Department of Defense is not necessarily eligible to participate with the VA. Now I know we have expanded that net. But to a large extent, it was not.

Mr. GRIFFIN. You know, Dr. Daigh served our country in the Army. He was an Army doctor for more than 20 years. He is well versed on coverage that is available to retirees in addition to veterans, so let me ask him to speak to the options that are available.

Dr. DAIGH. I am not sure I can address it very factually except to say that you are correct, not all veterans are eligible for care in the VA. And generally the VA I believe was set up to take care of the indigent and those who were disabled in combat or otherwise. So the inclusion recently of all veterans who returned from the Wars has certainly expanded the eligibility for VA. And then when category eights were allowed to join, that would be people who are veterans but are not financially disqualified from previous groups, that has significantly increased the number of people who could come. But the gates to get in and not get in have been changed over time. That is about all I know about it right now, ma'am.

Ms. BROWN. Okay. But we have expanded that area. And which I applaud. But in expanding it it created additional problems as far

as processing them through the system. I recently spoke to a veterans group and they indicated that it was such a horrible experience. And I said, well what was the horrible experience? Once you got into see the doctor? No, when I went for my appointment the person at the desk was on the phone and they did not stop and take care of me. That, I understand we lowered the job description of the front desk person so that veterans when they come in are not necessarily getting the right kind of experience that could have happened in any of our other offices if you do not have a person that is the first contact not a person at a certain level to, for that intake.

Dr. DAIGH. Yes, ma'am.

Ms. BROWN. I guess I was asking the question as to how could we improve the system as far as veterans feeling that the system, once that person got in with the doctor everything was fine. But it is just getting that person into the system.

Dr. DAIGH. Well, I think there are a couple of things. One is the systems that, by which you make appointments, that you make consults, the communications systems which are actually quite complex between VA. And in Phoenix we found for example that many patients who traveled to Phoenix part-time, snow birds if you will, they had a very difficult time getting into care. They were sort of blocked out of the primary care group that was set up and their access was diminished. So I think you have to look at what you mean by access to care as a system. You are going to have to implement the systems to make it work, mostly computer systems. And then I think you also have to incentivize everyone who works in the VA to have a customer focused, friendly, polite, how can I help you, I cannot help you too much attitude. So I think all those issues are part of what I believe the current Secretary understand and what I believe he will try to work on.

Ms. BROWN. Thank you. I yield back the balance of my time.

The CHAIRMAN. Thank you, Ms. Brown. Mr. Jolly, you are recognized.

Mr. JOLLY. Thank you, Mr. Chairman. Mr. Griffin, I have questions, and Dr. Daigh, about the analytical model behind your statements. And it goes to what Mr. O'Rourke said, and Mr. Roe, and Mr. Huelskamp. It matters not to me if VA influenced this report. I take you at your word to suggest it did not substantively influence your statements. The IG Office at Bay Pines is in my district. So believe it or not I hear constituent concerns, complaints, and compliments about the IG in a way maybe other members do not. What I know is words matter. And so your statement that you cannot conclusively assert that the lack of timely care caused the death of veterans certainly is an accurate statement based on your analytical model. Can you also conclusively assert that wait lists did not contribute to the deaths of veterans?

Dr. DAIGH. No. I, no.

Mr. JOLLY. And did you say that in the report? Was that reflected in the report?

Dr. DAIGH. I, I——

Mr. JOLLY. That you could not conclusively assert that wait lists had no contribution?

Dr. DAIGH. No.

Mr. JOLLY. And why not?

Dr. DAIGH. What I had hoped was that——

Mr. JOLLY. Hold on a minute. Let me go through this line of questioning. Because this is very important.

Dr. DAIGH. This is, this is why not. We put in here the stories of all these people who we thought did not get proper care. And it was my assumption that by reading these stories you could understand where the rate, where the waits were and you could arrive at your own conclusions——

Mr. JOLLY. I understand. You made a very powerful statement based on an analytical model that has not been reflected on the other side of the equation. And the reason it matters is because for six months we have been investigating the deaths of veterans. And IG words matter. Frankly more than any political appointee. We challenge political appointee words all the time and a lot of times they are wrong and misleading. We expect the IG not to be. And so the statement you made that you cannot conclusively assert that it led to deaths is a substantive statement that addresses work we have done six months, and yet you did not assert that it may, that you cannot conclusively assert it did not. Right? So you can say it did not cause. Would you be willing to say that wait lists contributed to the deaths?

Dr. DAIGH. The first 28 cases——

Mr. JOLLY. Would you be willing to say that wait lists contributed to the deaths?

Dr. DAIGH. Yes.

Mr. JOLLY. You would.

Dr. DAIGH. In fact the title of the first 28 cases are cases where we thought patients were harmed because of the wait lists.

Mr. JOLLY. Did it contribute? Did it——

Dr. DAIGH. There were six deaths out of that group.

Mr. JOLLY. Did it contribute to the death?

Dr. DAIGH. Yes.

Mr. JOLLY. Wait lists contributed——

Dr. DAIGH. Yes.

Mr. JOLLY [continuing]. To the deaths of veterans?

Dr. DAIGH. No problem with that. The issue is caused, or——

Mr. JOLLY. Of course.

Dr. DAIGH [continuing]. A direct relationship. How tight a relationship do you want? That is where, that is where the difficulty is here.

Mr. JOLLY. I understand. But that puts you down a road that gets very interesting. Because as you said earlier you have, you have no ability to determine the cause of death. When then asks at the very beginning what is the point of the study? If you are not able to make a determination then the analysis that suggests you cannot draw a causation creates a great question that actually undermines most of what is in the report. Whereas if you say it contributed to, that should be the headline. We have talked a lot about headlines. And if you are an American person sitting at the kitchen table today and in April learned that there were 40 deaths, we can play with semantics all we want, Mr. Griffin. But right here at the table it was acknowledged by the IG's Office that the wait lists con-

tributed to the deaths of veterans. That is an accurate statement, right doctor?

Dr. DAIGH. That is an accurate statement.

Mr. JOLLY. Mr. Griffin, would you agree with that as well? That the wait lists contributed to the cause of death in veterans?

Mr. GRIFFIN. I think in our report a careful reading would show that in some of those cases we say that they might have lived longer, they could have had a better quality of life at the end, and so on.

Mr. JOLLY. Sir, I——

Mr. GRIFFIN. Is that true or not?

Mr. JOLLY. Would you agree that wait lists contributed to the deaths of veterans? It is a yes or no.

Mr. GRIFFIN. I would agree——

Mr. JOLLY. Please, yes or no.

Mr. GRIFFIN. No, I——

Mr. JOLLY. Words mean something and you need to be precise with your answers.

Mr. GRIFFIN. Yes, they do.

Mr. JOLLY. Yes, you do?

Mr. GRIFFIN. No. I would say that it may have contributed to their death. But we cannot say conclusively it caused their death.

Mr. JOLLY. Of course. And you cannot say conclusively it did not. And so Dr. Daigh said we will use the word contribute. And he said it did contribute. You are not willing to say it contributed, is that right?

Mr. GRIFFIN. No, that is not right.

Mr. JOLLY. Well then you are willing to say——

Mr. GRIFFIN. I think what the report says is it may have contributed and there is no denying it may have contributed.

Mr. JOLLY. So you are undermining the confidence we have in the IG by not being able to answer that very simple question.

Mr. GRIFFIN. No, I answered——

Mr. JOLLY. Did it contribute to the deaths of veterans, yes or no?

Mr. GRIFFIN. It could have.

Mr. JOLLY. Okay, that is your answer.

Mr. GRIFFIN. That is right.

Mr. JOLLY. And I know Dr. Daigh disagrees with you. In law——

Mr. GRIFFIN. I do not think he disagreed with you.

Mr. JOLLY. He answered it very differently.

Dr. DAIGH. For the——

Mr. JOLLY. He did. And listen, I am going to conclude with this.

Dr. DAIGH. Yes, sir.

Mr. JOLLY. In law there is the notion of res ipsa loquitur, the facts speak for themselves, in cases of negligence and death. We know people were on the waiting lists. We know they died as a result of conditions for which they were awaiting treatment. And we know that your office has made criminal referrals related to that. And so I appreciate Dr. Daigh you at least willing to say wait lists contributed to the deaths of veterans. Because that is not the story that has come out as a result of the IG report. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you very much. Mr. Schweikert.

Mr. SCHWEIKERT. Thank you, Mr. Chairman. And Mr. Chairman and to the Ranking Member, I appreciate you letting me sit in on this committee. I have the opportunity and the joy of actually representing a large area of Phoenix. And have had a number of the folks that shall we say have been affected by the VA in my office. We have sat down with them over coffee. And this is one of those difficult subjects. Because for those of us from sort of the accounting math world we want to say is it binary, is it yes and no, as the discussion we were just having. And the reality whenever we deal with people, people, human beings, our health is not necessary binary, yes or no.

But some of this is really tough. I mean, a few months ago the sit down coffee with the widow, and you think of yourself as a really tough guy, that you have dealt with lots of this, and you are driving home, and you cannot get that lump out of your throat, and you are trying not to cry. And you have not cried since you were a child. So hopefully everyone here understand the emotional impact. Now we sort of work through the mechanics of what does this report really say, and what are the fixes? How do we never, ever, ever have these types of hearings, and these sorts of experiences, and I never sit down with a widow that breaks my heart every again?

And first, for Mr. Griffin, I just, maybe it is the term of art. But very quickly, when going through the report the words significant is rolled through a number of times. Was it a significant causation? Was it a significant factor in the death? You do see within the questions of both the right and the left here how many times we say significant and it can have a wide interpretation. Is that how you meant to write it? Was that the goal, saying look, there is a wide path here of causation?

Mr. GRIFFIN. Our clinical staff did those reviews. I would ask Dr. Daigh to answer your question.

Mr. SCHWEIKERT. And Dr. Daigh, I am trying to be really fair minded here and not, you know, let my emotion drive my questions. Am I being fair minded?

Dr. DAIGH. I think so. I think first of all it takes a great deal of effort for the people that work for me to write these stories with no emotion. And so what people read when they read these stories is an emotionless layout of fact. You do not see the outrage we feel. So if we start from a universe of patients who all were delayed in getting their care, it is reasonable to assume that they are all harmed just by the fact they did get delays in care.

Mr. SCHWEIKERT. Okay. And Dr. Daigh, you sort of nudged up to something I just want to touch on just as an observation. I was actually a little disturbed by, and Mr. Griffin I will write you a note of this and hopefully we will just do it in writing, the fact you knew there were 800 articles. IG, facts, facts, facts. Promise me you are not tracking the press articles and saying, oh, we are up, we are down, oh, they did not see it as nicely. That is our world. That is not, never, ever, ever should be the auditors' world. And it bothered me that you knew there had been 800-some articles.

Two quick things. Tell me what you learned from the hotline. Did the hotline ever, did you ever map out a pattern or a division

or a specialty that there was something wrong? Something came up repeatedly? And it could be doctor or Mr. Griffin. Whoever——

Mr. GRIFFIN. Let me just respond to the 800 articles very briefly. It took about 60 seconds to determine that——

Mr. SCHWEIKERT. The sheer fact you had any curiosity at all——

Mr. GRIFFIN. It was not curiosity. We were being challenged for the fact that we alluded to the original allegation of 40 deaths, and that is what got reported over and over and over again.

Mr. SCHWEIKERT. And once again you work for ultimately us, the taxpayers, the agency, not the media. The media should never influence the professionalism of what you do. So doctor, sorry, you were moving up to the microphone.

Dr. DAIGH. Would you repeat the question, sir?

Mr. SCHWEIKERT. It just, tell me, any patterns from the hotline?

Dr. DAIGH. I would say that the pattern that we saw in the cases was not that, was essentially people who were denied their care because they were on wait lists. And the hotline cases were usually a little more clear in the delay or the impact of, for us, the timing of not getting care and then being able to see impact was clearer in the hotline cases than it was on the long list of cases we looked through who people who were delayed tried to determine whether there was an impact.

Mr. SCHWEIKERT. Mr. Chairman, I appreciate——

Dr. DAIGH. The urology group, the urology clinic was one area that became clear to us——

Mr. SCHWEIKERT. Where you saw a pattern?

Dr. DAIGH [continuing]. We saw a pattern. The other pattern was that people had a very difficult time getting into primary care. So if you were already impaneled in primary care at Phoenix, which was an inadequate panel size, then you had at least one access to get consults or move your way through the system. If you were not in the primary care panel, then you had a very difficult time navigating the system.

Mr. SCHWEIKERT. Okay.

Dr. DAIGH. I would say those would be two examples that——

Mr. SCHWEIKERT. And forgive me. Mr. Chairman, thank you for your patience. I will, for all of you I actually have some written questions that I will shoot your way. Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Benishek.

Dr. BENISHEK. Thank you, Mr. Chairman. I guess the question that I, comes up, and the chairman brought it up, and the thing that concerns me the most about this is that this is really bad stuff that happened to our veterans. And the care that was outlined in the, I read through those cases that we have here. I do not know, like 40 cases. These case summaries. And I know they are incomplete, but boy, I, you know, just to see how our veterans have suffered and subject to delays in care that was most evident from these short excerpts here. That, you know, your argument that the delay did not, the causation, with the death. I mean, I understand that, that argument. But the delays that occurred here, boy, they certainly would be unacceptable in my practice. Where if you referred somebody to a short term follow up and then due to a screw up of scheduling, you know, a two-day follow up did not occur for

months. And you know, this is just unacceptable. And I think that, I think you all agree on that. Is that right? Doctor——

Dr. DAIGH. Sir, the title above the first 28 cases is clinically significant delays. So I completely agree with you. The only point that I wish——

Dr. BENISHEK. Well I——

Dr. DAIGH [continuing]. Wish we had worded better was this idea that delay caused death. That was——

Dr. BENISHEK. Well the only thing that upsets me about this is that somehow the media has taken that there is no problem, or there is not that big of a problem. This is a big problem. This is a huge problem. This is a problem that has to be addressed. And you know, hopefully with the changes that are happening in the VA now, we have a new Secretary, and reform, and hopefully a new culture within the VA, that that will happen. I think we all just want to be sure that we have an Inspector General that we can rely on to be inspecting independently of VA coercion or enforcement or discussion. And I think that is really the gist of where I, what I get from this hearing. Mr. Griffin, do you want to comment on what I just said?

Mr. GRIFFIN. I do. I do. We do not have an Inspector General right now in our office. It is a presidential appointment. It has been vacant since January 1st. Everybody who worked on this report is a career federal employee. We do not pick sides. I think the rigor of our interim report issued on May 28th led to very large change in the department, including the most senior leadership. I think the 24 recommendations in this report address the issues that we found. And the notion that, that somehow we would have issued either of these reports if we were complicit with the department just does not wash with me.

Dr. BENISHEK. I mean, let me just go over in a different direction, and I missed some of the hearing because I had to do another thing. But has anybody been prosecuted? I mean, has people——

Mr. GRIFFIN. There are——

Dr. BENISHEK. [continuing]. Referred to the Department of Justice for prosecution——

Mr. GRIFFIN. There are ongoing investigations.

Dr. BENISHEK. So nothing has happened yet?

Mr. GRIFFIN. No one has been prosecuted yet.

Dr. BENISHEK. I see. Have you heard from the Department of Justice? Have you, are they——

Mr. GRIFFIN. We have heard from the Department of Justice. The Assistant Attorney General for the Criminal Division sent guidance out to all the U.S. Attorney's Offices laying out for them his view of what the potential charges could be based on his knowledge of the manipulation of records, potential destruction of records, and so on. That was sent to every U.S. Attorney's Office in the country. We are working in partnership with the FBI on the ongoing Phoenix investigation and in a number of the other locations. Believe me, we have no desire to see people escape who deserve criminal charges. As I mentioned earlier, we arrested 94 VA employees last year on charges unrelated to waiting times. So we are not bashful about arresting people when they break the law.

Dr. BENISHEK. So you do not know the timeline when this is going to be done?

Mr. GRIFFIN. I think, I think as we complete the investigations it is going to be a rolling process. It is not like there is a date certain when all 93 will be closed. But every week we will make additional progress. And if they are not prosecuted——

Dr. BENISHEK. Are you doing more referrals? Did you do any referrals to the Justice Department in the last week?

Mr. GRIFFIN. I think we had a new case last week in Minnesota.

Dr. BENISHEK. All right.

Mr. GRIFFIN. Whenever we open a case that has criminal potential the Attorney General guidelines require us to notify the FBI——

Dr. BENISHEK. Right.

Mr. GRIFFIN [continuing]. So that we are not duplicating efforts.

Dr. BENISHEK. I am sorry. Thank you for your indulgence, Mr. Chairman.

The CHAIRMAN. Thank you very much, members. The Secretary has been waiting well over an hour now to come and appear. So I appreciate your indulgence for waiting through the vote series. I do have, again, I have learned a lot in this hearing today. I honestly had no idea that the OIG would go back and forth with drafts to the VA. I was under the impression that it was a single draft that went to them to be checked for factual corrections that needed to be made. I would ask that you provide the committee copies of the drafts that were done. The fact remains that from the very first draft there was no inclusion of the statement that has caused me concern. Because it did, it took away the entire focus from all of the work that your office had done. So much so that it was leaked, just that part, prior to. In fact, I think it even caused you to move up the release of the final report because it exonerated the department. Well it did not exonerate the department. And I just, you know, I do not think anybody here thinks that it did.

Mr. GRIFFIN. I do not think it did. Mr. Chairman, I am sorry to interrupt. But I do not believe it exonerated them, one bit.

The CHAIRMAN. Well, now and here is the question that I still, I need to ask before we close. In your testimony you gave the impression that the committee suggested that the appropriate standard to be used to determine causality of death is to unequivocally prove, I think that was a comment that you made, that a delay in care caused death. And reading the document that you in fact cited as an exhibit in your testimony it states that a committee staff member sought specific information in order for this committee to prove that delays were related to death. And so what I need for you to tell me is do you believe that caused and related mean the exact same thing?

Mr. GRIFFIN. I think the context of this document, which is Attachment B for those who would like to review it. It is Attachment B to our statement. It reads, "In order to unequivocally prove that these deaths (all 40) are related to delays in care." Now the document——

The CHAIRMAN. Comma——

Mr. GRIFFIN [continuing]. Includes 17 names——

The CHAIRMAN. Comma——

Mr. GRIFFIN [continuing]. But it says all 40.

The CHAIRMAN. Comma——

Mr. GRIFFIN. That is why we were in pursuit of the 40.

The CHAIRMAN. You did not finish. You did not finish. There is a comma there. It says, "O&I," which means Oversight and Investigations, "needs access to VA's computerized patient record system to pull up these veteran files or to request them from VA."

Mr. GRIFFIN. Right, to unequivocally prove.

The CHAIRMAN. For the committee.

Mr. GRIFFIN. Yes.

The CHAIRMAN. Not you, but the committee.

Mr. GRIFFIN. Does the, does the committee have the clinicians to make that determination?

The CHAIRMAN. I do not know that that is, you, in your testimony, though, you are saying that we put that burden on you. That burden was not placed on you. We said that about ourselves. Whether we have the clinicians to do it or not is not relevant. The fact is you were saying that we said that. And my question is, is caused and related, do they mean the exact same thing? Now you are saying they do.

Mr. GRIFFIN. No. What I am saying is unequivocally prove is an extremely high standard and it is not the standard that Dr. Daigh's people were using. That is all I am saying.

The CHAIRMAN. And we did not ask, and we did not ask for that, correct?

Mr. GRIFFIN. No, no. Your memo that was sent to us on April 9th after the hearing said that in order to unequivocally prove that these deaths, all 40, remember they were potential deaths, and as continued on it was declarative that there were 40, that all 40 are related to delays in care.

The CHAIRMAN. O&I, meaning the committee.

Mr. GRIFFIN. Right.

The CHAIRMAN. So, again, the unequivocal was not placed as a burden, was not placed on you, it was placed on us. We placed it on ourselves.

Mr. GRIFFIN. Yes, you did.

The CHAIRMAN. Okay. But it was not placed on you. And that——

Mr. GRIFFIN. Well this——

The CHAIRMAN [continuing]. You alluded to that——

Mr. GRIFFIN. I did allude to that. Because this was sent down here on an email by your staff saying here are the, here are most of the documents, meaning documents that surfaced in the April 9th hearing, and this document comes down with 17 names. And it says we are going to unequivocally prove that all 40, well there is only 17 names. I mean, it is, it is——

The CHAIRMAN. That is, again sir, that is, I am sorry, but that is, you are trying to say we set a higher standard for you to prove when we did not set that standard. Is that correct?

Mr. GRIFFIN. I will let the document speak for itself.

The CHAIRMAN. But you——

Mr. GRIFFIN [continuing]. That is why we put it on the record——

The CHAIRMAN. But you made the testimony. You are testifying to the fact that we set that bar for you to meet. We, that, this clearly says in order to unequivocally prove that these deaths, all 40, are related to delays in care, O&I needs access, O&I meaning the committee, not you. But you took from this that we were trying to set a standard that you could not meet. In fact, I think Dr. Daigh said something about a standard that could not be met. And I, I am just, again we are having communication issues. And I understand that. But we——

Mr. GRIFFIN. I would be pleased, I would be pleased to answer for the record the other suggestions that came from the committee as to how this should be done, including one that was sent to us as the ink was drying on the final report. Which had we modified would have been a violation of general government accounting standards.

The CHAIRMAN. Well again, we, I am talking specifically about something you included and you are saying that this was a directive to you to meet a standard you could not meet, unequivocal. Is that true or not?

Mr. GRIFFIN. The document staff says so O&I staff can look at this. That is fine. Why was it sent to us if O&I staff wanted to look at these things? They could have asked the department for these medical records. Clearly we were being asked, as a matter of fact in some circles it says we were ordered to expand our investigation in order to look into the issues——

The CHAIRMAN. Not, not from this, not from this committee. I mean, if you have proof let me, tell me what it is.

Mr. GRIFFIN. Well, I am telling you what has been reported, that we were ordered——

The CHAIRMAN. Oh, you are reading, you are googling again?

Mr. GRIFFIN. No. You can make all the fun you want of that. That is a reality that the basis for this thing getting eggs was the allegation of 40 specific deaths and we just could not find the trigger for those 40. Instead of looked at 3,409. So I do not understand——

The CHAIRMAN. And you found 293 deaths.

Mr. GRIFFIN. Right, there were 293 dead out of that number.

The CHAIRMAN. And you now have a statement that says that you could not, and then I am through, you cannot conclusively or otherwise, whether these deaths were related to delays in care. That, that is, and that was inserted after the first draft, correct? Can you——

Mr. GRIFFIN. That is correct. And we have been down this road. There were multiple drafts——

The CHAIRMAN. Yes. I have learned, and I told you I learned that.

Mr. GRIFFIN. On July 22nd one of our staff in a senior, tracking changes on the report, which you will see, indicated if we cannot conclude this we should say so. Eventually that is what we got to.

The CHAIRMAN. And so you can also——

Mr. GRIFFIN. Now——

The CHAIRMAN [continuing]. Can you conclusively say that no deaths occurred because of delays in care?

Mr. GRIFFIN. No. We do not know. It is the causality thing, which is bore out in the testimony for the record from the witness who is not here today who is the President of the National Association of Medical Examiners. I do not know who requested this, but he says we got it right. So people are entitled to their own opinion. Whether we——

The CHAIRMAN. Thank you. I appreciate very much your testimony.

Mr. GRIFFIN. Thank you, Mr. Chairman.

The CHAIRMAN. You have a job to do and we appreciate the job that you do. We have a job to do as well. I appreciate the committee members for their questions and you are now excused.

And we will take just a second. The Secretary will be coming in so we will have our second of three panels.

We are going to hear from the Honorable Robert McDonald, Secretary for the Department of Veterans Affairs. Mr. Secretary, first of all we apologize for keeping you waiting for so long. He is accompanied by Dr. Carolyn Clancy, Interim Under Secretary for Health at the Veterans Health Administration. Your entire statement will be made a part of the hearing record. We would like to say welcome to you, to our committee room. We look forward to working with you in the future. And you are now recognized for your opening statement.

STATEMENT OF HON. ROBERT A. MCDONALD

Secretary MCDONALD. Thank you, Chairman Miller. I look forward to working with you and the rest of the committee to improve the Department of Veterans Affairs to provide the kind of care that our veterans deserve.

Chairman Miller, Ranking Member Michaud, and members of the Committee on Veterans' Affairs, thanks for this opportunity to discuss with you VA's response to the recent VA IG report on Phoenix.

First, let me offer my personal apologies to all veterans who experienced unacceptable delays in receiving care. It is clear that we failed in that respect regardless of the fact that the report on Phoenix could not conclusively tie patient deaths to delays. I am committed to fixing this problem and providing timely, high quality care that veterans have earned and that they deserve. That is how we will regain veterans' trust, and the trust of the American people.

The final IG report on Phoenix has now been issued and we have concurred with all 24 of the report's recommendations. Three of the recommendations have already been remediated and we are well underway to remediating many of the remaining 21 because we began work when the IG's interim report was issued in May.

We have proposed the removal of three senior leaders in Phoenix and we eagerly await the results of the Department of Justice investigations. Nationally there are over 100 ongoing investigations of VA facilities by the IG, by the Department of Justice, by the Office of Special Counsel, and others. In each case we look forward to receiving the results so that we can take the appropriate disciplinary actions when the investigations are complete, when we have the evidence, and when we know the facts.

We are grateful for the committee's leadership in establishing the recently passed Veterans Access Choice and Accountability Act of 2014. This law streamlines the removal of VA senior executives and the appeals process if misconduct is found. However, it does not eliminate the appeal process, the guarantee that VA's decisions will be upheld on appeal, or allow VA to fire senior executives without evidence or cause. And it applies only to senior executives, who are less than half of one percent of VA's employees.

Now we have taken many other actions in Phoenix and the surrounding areas to improve veterans' access to care including, first, putting in place a strong acting leadership team. These are good people with proven track records of serving veterans and solving problems. Increasing Phoenix staffing by 162 personnel and implementing aggressive recruitment and hiring processes to speed recruiting. Reaching out to all veterans identified as being on unofficial lists or the facility electronic wait list, and completing over 146,000 appointments in three months. As of September 5th there were only ten veterans on the electronic wait list at Phoenix. Where VA capacity did not exist to provide timely appointments we referred patients to non-VA care. From May through August Phoenix made almost 15,000 referrals for non-VA care. We have secured contracts to utilize primary care physicians from within the community in the future.

Since my confirmation as Secretary 51 days ago I have traveled to VA facilities across the country, including Phoenix, speaking to veterans and VA employees as well as visiting and speaking with members of Congress, veterans service organization, and other stakeholders. During those visits I found VA employees to be overwhelmingly dedicated to serving veterans and driven by our strong VA institutional values of integrity, commitment, advocacy, respect, and excellence held in this acronym I CARE.

We will continue to work with the IG and other stakeholders to ensure accountability. As I said, there are over 100 ongoing investigations at VA facilities by our IG, by the Department of Justice, by the Office of Special Counsel, and others. In each case we await the results and will take the appropriate disciplinary actions when all the facts and evidence are known. But we will not wait, and I want to emphasize that, we will not wait to provide veterans the care that they have already earned.

Going forward we will focus on sustainable accountability. More than just adverse personnel actions, this means creating a culture where all employees understand how their work, their daily work, supports our mission, our values, our strategies. It requires supervisors to provide daily feedback to every subordinate, to recognize what is going well and identify where improvements are necessary. We are moving forward on several fronts and I have discussed these major initiatives with the chairman and ranking members of the Veterans' Affairs Committee and with many of the members here.

Last week we announced the beginning of our Road to Veterans Day, focusing on the next 60 days. We are focusing on three strategies, rebuilding trust with veterans and the American people; on improving service delivery; and importantly on setting the course for long term excellence and reform.

This week we released our Blueprint for Excellence. Dr. Carolyn Clancy, on my left, and Dr. Jonathan Perlin, a former Under Secretary for Health and now the Chief Medical Officer at HCA, one of the largest medical providers in the country, helped us lay out this blueprint. Four broad themes, ten essential strategies to help us simultaneously improve the performance of VHA Healthcare now; develop a positive culture; transition from sick care to healthcare in the broadest sense; and develop efficient, transparent, accountable, agile business and management processes.

And to increase timely access to care we are recruiting to hire more clinicians. As part of that effort I have proposed increases to the minimum and maximum rates of annual pay for eligible VA physicians and dentists. With more competitive salaries we will be better positioned to attract and hire more healthcare providers to treat veterans and will be better positioned to retain those who are performing at a high level.

We will judge the success of all our efforts against a single metric, and that is veterans' outcomes. We do not want VA to meet a standard. We want VA recognized as the standard in providing healthcare and benefits. I know we can fix the problems we face and I know we can utilize this opportunity to transform VA to better serve veterans.

Mr. Chairman, members of the committee, thanks for your unwavering support for veterans. I look forward to working with you in implementing the law and in making things better for all of America's veterans. Dr. Clancy and I are prepared to take your questions.

[THE PREPARED STATEMENT OF HON. ROBERT MCDONALD APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Secretary, very much for your testimony. I have a number of questions in here that are I guess designed to rip and punch and do all kinds of things. And I am not going to do that. I, this committee is committed to being a full and complete partner with you as you work towards repairing the damage that has been done to VA over a number of years. Not just recently but over a number of years. And I think what we want to know is, and you have only been there 50 days, do you have the tools that you need or are you finding that you need more? And we talked about this at breakfast last week. That we need to help you with legislatively, so that you can make the changes that are necessary to deliver the benefits to the veterans that have earned them.

Secretary MCDONALD. Mr. Chairman, thank you. We have gone through and looked at the legislation that governs our department. And we have put together some proposals which are currently with the Office of Management and Budget. And we would enjoy the opportunity to be able to share those with you within the next few weeks as we get them back from the Office of Management and Budget.

We have a lot of tools at our disposal, and as I said I thank you for the act that you all passed. It was a great show of bipartisanship for our veterans. But I think there are going to be things that we could use help with. And longer term I know that we will con-

tinue the conversation so that we can work together to identify those legislative needs.

The CHAIRMAN. I think you are probably going to hear from both sides that it appears that nobody has been fired yet. I know that the wheels have begun. But, you know, at some point, we are at 110 days and, you know, is it that hard in the federal system or at VA to fire somebody who has been caught red-handed doing something?

Secretary MCDONALD. Well first of all coming from the private sector, having run a $84 billion global company, it is a misperception to think that even in the private sector you walk in one day and you fire someone. It is frankly a failure of what I call sustainable accountability. If you are doing a good job managing an individual you are giving them daily feedback. And that daily feedback should result in a relationship that when something goes awry the action can be taken quickly but with the due process allowed.

In our particular case around 65 percent of our employees are union members and our ability to separate them from their jobs depends upon the specific union contracts that we have in our facilities. As I said, the revision you all made in the new act does shorten the appeal time for our senior executive service employees. And we welcome that. But there still is a due process.

As you know, in Phoenix we have got two senior executive service people who we have proposed action against. We give you a report every week. The report we gave you I think yesterday has 19 separate disciplinary actions on it. And we are going to work with you to continue to track it and keep you up to date as we learn new information. We need to get these investigations done and I was pleased to hear that the Inspector General thinks we can get them done relatively quickly.

The CHAIRMAN. Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman. And I want to thank you, Mr. Secretary and Dr. Clancy, for being here today. And I want to say from the outset, Mr. Secretary, I am very pleased with what I have seen so far with your leadership style and the fact that not only have you taken the time to visit with employees at the VA, which has not been done as my understanding in the last five years, but your willingness to reach out not only to members of Congress, and particularly this committee, but also the veterans service organizations to get their input and insight into how we can provide better services for our veterans. So I really do appreciate that.

And as I mentioned when we met before you were confirmed a Secretary that, yes the VA is going through some turbulent times right now. But it is also a time for opportunity to really change the cultural structure within the department and its employees, but also a time to really think big on a national strategy and where we should be going as far as the Department of Veterans Administration. So I want to thank you for your willingness to step up to the plate.

Some of my questions, you mentioned about the 24 recommendations under the OIG report, how long do you think it will take you to complete all of those recommendations?

Secretary MCDONALD. We have actually put that in our report and I think it is by the end of about 2016, 2015. But of course it is over time and it depends upon how systemic and how big the changes. We are meeting every week and trying to get those remediations done. And I separately have asked the IG for all past IG reports that have not been remediated. I would like to go back and look at the history and understand what we need to do on the things that have not been remediated. Because my understanding from the IG is there is quite a few things. Believe me, having run a public company, having been on two audit committees on two different boards of directors, I like what the IG does. I need the IG's help. We all need the IG's help. And the work that they do is critically important to us in improving the organization.

In fact as I have gone to these various sites, I have now been to nine different cities, 21 different operations of the VA over my first 50 days. I tell people that I want every employee to be a whistleblower. I want every employee helping us change the IG. So I welcome the criticism that anyone has. I even perhaps made the mistake of giving out my cell phone number publicly. It has been published online. It is in the Washington Post. And I have answered 150 phone calls so far.

Mr. MICHAUD. Thank you. Speaking about the whistleblower, I know that is still a concern talking to some VA employees about whether or not they will be protected when they come forward. When will the VA be certified by the Office of Special Counsel, Section 2302(c), on the whistleblower protection?

Secretary MCDONALD. Well I and Deputy Secretary Gibson, the interim, or acting, have demanded from the very beginning that whistleblowers be protected. I will have to get back to you with a specific date on that.

But one of the things I have tried to do, because this is about changing culture and I know many of you asked about changing culture, is as a leader your behavior is looked at as a demonstration of a new culture. When I go to sites, those 21 different sites I talked about, I asked to meet with the whistleblowers. I asked for the whistleblowers to be in the town hall meetings. I asked for the union leadership to be in these meetings. We cannot do this alone. We have to get every employee in the tent and working together so our veterans benefit.

Mr. MICHAUD. A lot of the focus has been on VHA because of the Phoenix, Arizona. Do you have any plans to look at VBA and the National Cemetery Administration for similar leadership shortcomings and integrity type of issues?

Secretary MCDONALD. Yes, sir. In fact as you and I had talked, part of our problem in VA is we are a siloed organization. We have been brought together over the years without really any idea to integrating the organization. As we talked, we have nine different geographic maps of organization structure for VA. That means no decision, nobody represents the Secretary of Veterans Affairs at any lower level than the Secretary or the Office of the Secretary. We simply have to get that fixed. It is a long term effort. It is part of our Road to Veterans Day. It is in the third column, we say set the course for longer term excellence. But I want to get to a point where our organization is so simple for the veteran to understand

that they can plug into our organization any way they want, we will be there. If it is a smart phone for an Iraq veteran? We will be there. If it is paperwork for a World War II veteran? We will be there. And I want them to think of the VA as their VA. I want every veteran in this country to say this is my VA and I am proud of it.

Mr. MICHAUD. Well, once again I see my time is expired.

So I want to thank you once again, Mr. Secretary, for your leadership, your willingness to do this. I am very optimistic and very hopeful that with your leadership style that this change will continue in a positive direction, so I want to wish you the best of luck.

Secretary MCDONALD. Thank you, Your Honor.

Mr. MICHAUD. And thank you.

Secretary MCDONALD. It will take the partnership of all of us.

Mr. MICHAUD. Great, thank you.

The CHAIRMAN. Mr. Lamborn.

Mr. LAMBORN. Thank you, Mr. Chairman, and thank you, Mr. Secretary for being here today; we really appreciate hearing from you.

Secretary MCDONALD. Yes, sir.

Mr. LAMBORN. There are a lot of things we could talk about, but the need at the moment is to try to get to the bottom of what the details are surrounding this Inspector General's report that has just come out.

You may have heard the testimony of the Inspector General earlier today that while the waiting list in Phoenix contributed to some or all of the 40 deaths of veterans in Phoenix, it may be—it did not cause their deaths, and they made a distinction between contributing to their deaths and causing their deaths.

In light of that, was it misleading for some of the press headlines after a leak was made to have headlines like, "No deaths related to long waits," which was one, or another that said, "No links found between deaths and veterans care delays"?

Secretary MCDONALD. Sir, I am reacting as if every shortage of care, every shortage of access to care is incredibly important. Someone said it earlier, you have to think about this one veteran at a time. I am a veteran——

Mr. LAMBORN. Yes.

Secretary MCDONALD [continuing]. I do have injuries from my time in the service. I think about this—my father-in-law was a prisoner of war, he had post-traumatic stress, he was shot down in World War II. Until we got him to the VA we didn't know what the problem was. My uncle suffers from Agent Orange, 101st Airborne Division. So this is very personal to me.

Mr. LAMBORN. So——

Secretary MCDONALD. And so we are acting as if every shortage is absolutely important, and we are going to fix it, with your help.

Mr. LAMBORN. Okay. So are those headlines accurate?

Secretary MCDONALD. To me that—I am telling you I am going to act as if every veteran deserves the care they need and I am going to provide it to them, and that is what I am acting.

Mr. LAMBORN. Well, what do you think about the fact that someone in the—and the Inspector General said it wasn't someone in their office, leaked to the press an important sentence out of the

report before it was released to the public? Do you have any concern about that?

Secretary MCDONALD. I don't know anything about that.

Mr. LAMBORN. Is it any violation of VA ethics or rules or regulations or law to release something before public release?

Secretary MCDONALD. I don't know.

Mr. LAMBORN. Are you going to look into this?

Secretary MCDONALD. Well, we—certainly we have had lots of leaks all over the place. I read about Dr. Foote's testimony in the newspaper this morning.

Mr. LAMBORN. Okay. Let me change here——

Secretary MCDONALD. The important thing, sir, is to create a culture.

Mr. LAMBORN. Yeah.

Secretary MCDONALD. We have got to create a culture that is open and transparent and that works on veterans' issues, that looks at every single issue from the veterans' lens, okay?

Mr. LAMBORN. And I agree with that.

Secretary MCDONALD. And the three hours I spend waiting to testify is time I am not spending working on veterans' issues in the field where the veterans are being cared for.

Mr. LAMBORN. Okay, let me pursue something you were talking to the chairman about. I hear from veterans all the time that they are amazed that no one in Phoenix has been fired for the unacceptable waiting lists in Phoenix. Apparently——

Secretary MCDONALD. Sir, I said that we have proposed disciplinary action against two of the SES employees in Phoenix.

Mr. LAMBORN. Are those the two that are on paid leave?

Secretary MCDONALD. That—that is—that is currently under way. That is the rule of law. If you would like to change the law——

Mr. LAMBORN. We did change the law.

Secretary MCDONALD. Sir, you changed the law so it affects the appeal only.

Mr. LAMBORN. Yeah. So the two that are on paid leave, is that the extent of what we are going to look at as far as any kind of consequences?

Secretary MCDONALD. I think you heard Mr. Griffin say that the FBI and other investigative sources are in Phoenix right now, and you also have received a report from me every week that tells you the people who we are disciplining.

Mr. LAMBORN. Okay.

Secretary MCDONALD. The report we gave you yesterday has 19 people on it, we will track that report weekly, we will update it weekly, and we will make sure that we discuss with you whatever you would like to discuss about that report.

Mr. LAMBORN. Now, are those the people that the Department of Justice declined to do criminal prosecutions of?

Secretary MCDONALD. I am not familiar with those people, that is with Mr. Griffin. You would have to handle that——

Mr. LAMBORN. Okay.

Secretary MCDONALD. These are the people that we administratively feel should be called out and brought to task for what they

did, which is an important part of changing the culture, as the IG said.

Mr. LAMBORN. I—that is——

Secretary MCDONALD. We have to hold people accountable or you are not going to change the culture.

Mr. LAMBORN. Mr. McDonald, that is why I want you to take some action, because that is part of the culture.

Secretary MCDONALD. Sir, I am taking all the action the law allows me to take.

Mr. LAMBORN. Well, I will——

Secretary MCDONALD. With due process.

Mr. LAMBORN. We are here to help you and let us get it done.

Secretary MCDONALD. I know you are, and we have talked with the chairman about potentially working together on other legislative remedies.

Mr. LAMBORN. Okay.

Secretary MCDONALD. And we look forward to working with you on that.

Mr. LAMBORN. Okay. Thank you. Let us get it done.

Secretary MCDONALD. Yes, sir. Thank you.

Mr. LAMBORN. I yield back, Mr. Chairman.

The CHAIRMAN. Ms. Brown.

Ms. BROWN. Thank you, Mr. Chairman.

First of all welcome, welcome to the veterans' committee, and I hope in the future that we will have the common courtesy not to have the secretary waiting, even if we need to stand down one committee in order to bring you in, because I want you out there doing what—you should be for veterans. Thank you for your service.

Secretary MCDONALD. Thank you.

Ms. BROWN. As I mentioned when you came to my office, my first secretary, Jessie Brown, his motto was putting veterans first, and I like that, and yours is Road to Veterans Day, which is my birthday, November the 11th, but what exactly do you mean?

Secretary MCDONALD. For me the Road to Veterans Day is really about using the first 90 days that the chairman and the ranking member suggested to make as many changes as we can as quickly as we can to improve our service for veterans.

So as I said, we have three strategies. One is about rebuilding trust, and the effort I am doing to get around to talk to people, to learn about what is going wrong, all stakeholders, all shareholders, veterans themselves, we are compiling a list of the changes that need to be made.

At the same time we are forming teams of employees from without—from within the department. Part of the issue before was the organization was closed and wasn't communicating from bottom to top and top to bottom. We need to get employees involved in making these changes because they are the ones closest to serving the veterans. So we are in the process of putting that together.

That will form a strategic plan, we will roll out that strategic plan, we will make those changes. We will improve access, we will go ahead and get down a number of benefits in the backlog that we have, and it is all—it is all designed so that in the end the veteran will know how to plug into VA and think of this as their VA. That is really what we want.

Ms. BROWN. One of the problems that I guess I keep having with the whistleblower is that it always seems like it is negative, but I don't think feedback has to be negative, I think it should be a way that employees could come forward and say this is how the system can improve. I don't think every complaint should be viewed as us against them.

Secretary MCDONALD. Well, that is exactly right, and that is the culture we have to create. But I can understand that in this moment in time whistleblowers who had been retaliated against are skeptical as to whether I mean what I say or whether I can deliver what I say.

Ms. BROWN. Yes.

Secretary MCDONALD. The only remedy to that is to get out, talk to people, demonstrate it through our behavior, put in place a new leadership team which will believe in the culture that we believe in, an open culture that needs the people at the lowest level of the organization making the biggest changes, because that is how we improve our work.

Ms. BROWN. I like the army's motto, one team, one fight, and I think if we are all fighting to improve the situation for the veterans then we will do what we have said we have done for over 75 years, delivering assistance to the veterans that we can all be proud of.

Thank you very much for your service——

Secretary MCDONALD. Yes, ma'am.

Ms. BROWN [continuing]. And your committment, and I am sure that you have a lot of team members that are willing to work with you.

Thank you, and I yield back the balance of my time.

The CHAIRMAN. Thank you, Ms. Brown.

I can assure you while the secretary was delayed in coming and testifying he was working, because I actually went in the room and——

Secretary MCDONALD. The chairman is correct.

The CHAIRMAN [continuing]. Saw him—saw him meeting with individuals.

Mr. Huelskamp.

Dr. HUELSKAMP. Thank you, Mr. Chairman.

I would like to follow up on a couple questions Congressman Lamborn had, and thank you for joining us today.

The OIG report, maybe this a question for Dr. Clancy as well, what I didn't hear in the testimony and in—from the last panel was at what level at the VA in the collaborative process, that is the language from the OIG, is the report altered and the recommendations and changes? Is it at the secretary level or what level did that actually take place?

Secretary MCDONALD. It was not at my level, and I don't know. Before my time too.

Dr. CLANCY. I am sorry. We have an office within—that reports to the undersecretary, actually reports to the principal deputy undersecretary for health that routinely interfaces with the Inspector General, with the Government Accountability Office, and so forth getting clarification on recommendations, and frankly, tracks to see that we are on track with recommendations that we have agreed

with our dates and so forth, and as you heard from the Inspector General previously the issue of looking at a draft report and draft recommendations and they are asking for factual information to make sure that it is accurate is routine.

Dr. HUELSKAMP. What office is that? Could you provide that for the committee?

Dr. CLANCY. Sure, it is Management Review Services is what it is called.

Dr. HUELSKAMP. Okay. Who is in charge of that office?

Dr. CLANCY. Dr. Rasmussen.

Dr. HUELSKAMP. Okay. And I appreciate that, because there apparently was a leak that has created some concerns about that and I didn't know what level that was and that hadn't come out earlier and that was the—part of the concern, you were busy, didn't hear that testimony, but the concern about how many veterans were actually impacted.

And you might have missed as well, I had a line of questions with OIG that perhaps there were 5,600 veterans that escaped review during that process, and I am sure you are as concerned as I am about its impact potentially on veterans.

Two other areas of questions, I think my colleagues also mentioned the issue of the whistleblowers. Just last week we heard more harrowing stories from whistleblowers over retaliation, intimidation, retribution, these are the things that have all occurred in the last few weeks since you have been on board, and from their perspective what we heard in subcommittee last week very little has changed. Can you describe again and show me what your commitment is? Because this is on your watch and some of it is carried over, but we are still hearing those stories and that is very worrisome.

Secretary MCDONALD. Well, I have spoken to many whistleblowers in the organization myself. When I go to a location I ask to speak to the whistleblowers. I have had many of them call me on my cell phone and I have had conversations with them. And as I have said and as I have said publicly within the department and as I have said in every town hall I have held in the last 50 days, in 21 different sites, I welcome whistleblowing, I welcome people criticizing the operation, and I welcome employees who want to get involved on some of these reengineering teams that we are putting together so that they can help reengineer the process that they are criticizing.

So, I don't think there is any lack of clarity. I may have missed a site, I may not have talked to a particular person or it may be an activity that arrived before I did, but with the communications I have done, which have been two videos that have gone out to every employee, many letters, one of which, which you might be interested in, is a discussion of sustainable accountability and this whole idea of how do we get daily feedback going and how do we get the organization working together. I have met with the union leadership four times.

Dr. HUELSKAMP. Well, thank you for that, and I wanted you to restate that. I appreciate the commitment, because there are some folks between your level on down that haven't got the message.

Secretary MCDONALD. Well, tell them to call me.

Dr. HUELSKAMP. You know, check out our committee, subcommittee hearing from last week, that is your job, you have all the people to do that, we had a whistleblower. Hopefully you have checked on that. That came forward to the subcommittee and now this is still going on.

The third thing, I am glad you welcome criticism, because I want to see our rural areas of the country, the VS a doing a pretty poor job of meeting the needs of our veterans.

Secretary MCDONALD. In fact I am concerned about that myself.

Dr. HUELSKAMP. Exactly.

Secretary MCDONALD. I have been out to Nevada and have worked this—particularly in Nevada, I was in San Diego, we are working very hard on tele-health, we also think——

Dr. HUELSKAMP. Well, let me give you a better option, and that is in the bill, and that is VA choice, giving the veterans a choice.

Secretary MCDONALD. Well, that is in the bill.

Dr. HUELSKAMP. I know, but it can be implemented——

Secretary MCDONALD. And we have been doing it.

Dr. HUELSKAMP [continuing]. Fully and it may not be, and currently I understand our current law there are some options that there weren't used. But I am saying in my district I have veterans that go to four different VISNs, hundreds, 300, more than 300 miles——

Secretary MCDONALD. Yeah.

Dr. HUELSKAMP [continuing]. And I have VA employees say, well, too bad, get in a car and drive, but we need to make certain they have local options.

Even after this trial period is over, two years, I would hopefully like to continue to seek efforts at the VA to say, you know what, we can do a better job and provide that access closer to home, which is important for the veteran, but more important for the family and the local community that provides the services.

Secretary MCDONALD. Well, as I said, if you look at these issues through the lenses of veterans then the answer becomes very clear.

Dr. HUELSKAMP. Yeah.

Secretary MCDONALD. We want to get care to veterans.

Dr. HUELSKAMP. Yeah.

Secretary MCDONALD. If we don't have the technology, if distance is an issue, if capacity is an issue then we should help that veteran get the care in the private sector.

Dr. HUELSKAMP. The issue is not capacity, the issue is not distance, the issue is getting permission from the VA to go to the local hospital. If they are willing to do that, I just encourage you to look into that. I don't know if you have every lived in a rural area——

Secretary MCDONALD. Please give us their name and we will work on it.

Dr. HUELSKAMP. Okay, I will continue to do that. But the point is there are a lot of folks out there that would like that choice and we need to see that choice being offered by the VA.

So thank you, Mr. Secretary, I appreciate it. Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Huelskamp,

Mr. Takano.

Mr. TAKANO. Thank you, Mr. Chairman.

Mr. Secretary, welcome, this is the first time I have had a chance to meet you, I hope we have a chance to——

Secretary MCDONALD. We will get together soon.

Mr. TAKANO. Yeah, thank you.

Mr. Secretary, some of these—well, the Phoenix VA wait list scandal happened many layers below the secretary level, and how can you be sure that the leadership teams that are near you are going to be able to tell you the truth or be able to get to the truth and so you are not insulated and that you can count on people getting you accurate information?

Secretary MCDONALD. It is going to require a change in culture, and those of us who have experience running large organizations know that is probably the most difficult thing to do, but it starts with the purpose, values, and principles, which are the bedrock of any organization.

So the first thing I did was I asked for every employee to recommit themselves to the mission of caring for veterans and to the values of the organization represented in the ICARE acronym. We have used that as an leadership exercise for our leaders to talk with their employees about the mission, about the values.

The second thing that we have tried to do is we have tried to demonstrate that we want a very open culture. We talked about the positive aspects of whistleblowing, we have talked about the positive aspects of criticism. I have used a couple of diagrams. Most people think of an organization like this and the customers is on the bottom and the CEO is on top, but I turn that on its head and I said this is the VA we want. We want the veterans on top and those people who are next to the veterans every single day, the doctors, the nurses, the schedulers, the clinicians, those are the people that we should honor and make sure are paid properly and are rewarded, and then the CEO or the secretaries on the bottom, and the leadership's job is to make sure these people can properly care for veterans. This is a different kind of culture.

To demonstrate that I have cut down the size of the secretary's office, I no longer travel with the entourage that maybe once existed, and we are simply trying to make very visible that this is a different culture.

Mr. TAKANO. Are you sort of like the Pope, you know, travel in like a little tiny car?

Secretary MCDONALD. I am much less than that. Remember, I am on the bottom of the pyramid, I am flying coach.

Mr. TAKANO. Well, you know, I have to say I sympathize with my colleague, Mr. Huelskamp's four—he has three or four VISNs divided, I wish you could do something about that. I think there is—you know, if you could fix that I would certainly appreciate it.

Secretary MCDONALD. We talked with Ranking Member Michaud in his office about this. Again, the veteran should not be punished for having a barrier between VA and DoD. The veteran should not be punished for having nine different maps of organization structure. These are things that we have got to simplify so that every—I will give you another example. We have 14 different web sites that require different user names and password.

Mr. TAKANO. Wow.

Secretary MCDONALD. Now, I don't know about you, but I hate keeping track of user names and passwords for all these web sites. You should be able to plug in the VA in the easiest way and then get your care, and that is what we are working on.

Mr. TAKANO. You know, I am the ranking member of the Economic Opportunity Committee and I have a lot of concerns about the educational benefits, and I know you have been maybe paying attention to what has been going on in the for-profit college sector and making sure there is not undue predatory behavior.

Secretary MCDONALD. I got my MBA using the GI Bill. My dad and my father-in-law got their college using the GI Bill. Again, it is very personal. We cannot allow people to take advantage of our veterans, it is really that simple.

And I am thrilled with the work that was done in the new bill, I have told the chairman that, because you have expanded our ability to get doctors and nurses reimbursement for their study if they work for the VA, and we need more medical professionals. So that was a really big win for us.

I have been out to Duke University Medical School, I was talking to the dean of Pennsylvania University Medical School, Penn, and just two days ago I was in San Diego with the dean of UC San Diego. These relationships for us are critical and getting those doctors, nurses, particularly mental health professionals into VA is very important.

Mr. TAKANO. Well, I want you not to forget that I just wrote you a letter asking you for a plan on how we would use the medical residencies. That is a huge thing, you know, on the Medicare, Medicaid budgets, and we have been frozen in terms of the supply of doctors, and really we have a supply—we don't have a supply problem with the med students, we have a problem matching them to residencies, and I am looking forward to your ideas on how this can even help the broader community. Of course the primary function is the VA, and I think it will help the rural areas as well as impacted areas such as mine and Ms. Titus' and Ms. Kirkpatrick's.

Secretary MCDONALD. It is very important, in fact we talked with Congresswoman Titus the other day about this, we are working to develop a medical school at UNLV, University of Nevada Las Vegas, we want the residents to work for the VA at the Las Vegas Hospital. These are critically important things, and I think we are going to have to work together to get more medical schools contributing more graduates for our rural areas, and so I would offer that as something we would like to partner with you on.

Mr. TAKANO. I certainly would love to work with you on a plan like that.

Secretary MCDONALD. Yes, sir.

Mr. TAKANO. Thank you.

The CHAIRMAN. Dr. Roe.

Dr. ROE. Thank the chairman.

And first of all, Mr. Secretary, I thank you for taking the job.

Secretary MCDONALD. Yes, sir, thank you.

Dr. ROE. Thank you for your service to our country, and I certainly appreciate that, and I think I said during these long hearings we went through that if you ask someone at the VA who they work for they would say the VA, and the right answer was I work

for the veteran, and you got that right when you flipped that chart upside down.

And I also appreciate the fact that you just said that you know that the front of the airplane gets there only slightly before the back of the airplane does, so you can save a little money there, and anything is helpful.

Secretary MCDONALD. I used to jump out of them and I would not recommend that.

Dr. ROE. Well, I have done that a time of two and then questioned my sanity about why would anybody jump out of a perfectly good airplane, so.

Secretary MCDONALD. Particularly a doctor.

Dr. ROE. Yeah, exactly. Why would you do that?

I think one of the things that—a question I always ask our secretary every year when we come in with budget, is do you have enough money to carry out your mission, number one? And two, do you have adequate staff to carry out your mission?

And I think that is a question you may not have time to answer right now, but that is a question you will get next year when we go through the budgets. And we want to be sure that we provide the resources to take care of our veterans. And I can tell you the America people want their veterans taken care of.

And I know with Mark, Mr. Takano, we worked with him on that—on the residency slots, and I would like to personally offer you an opportunity to visit east Tennessee to our VA, and let me tell you why. It is one of five medical schools, it is now a 30-year-old school, it is on a VA campus. It actually was started with a T Cranston bill, so our students, our medical students actually go to the VA campus every day for their education and they go to the VA Hospital—along with the public hospitals too. It is a very good model, and maybe we should as we look at these shortages of physicians and we know that doctors are creatures of habit, we stay where we are like most people like to if you are comfortable, and it is a great way to get doctors to stay and make a career at the VA as Dr. Foote did. He was a career VA doctor.

So I want to—I don't really have any questions other than just to thank you for taking the job and——

Secretary MCDONALD. Yes, sir.

Dr. ROE [continuing]. You come from a great company, you have a great background, you have run a big organization before, so I think you are going to be a great secretary.

Secretary MCDONALD. Thank you, sir.

I would just say, and I know the chairman knows this, but 70 percent of the doctors in the United States have worked for the VA at one time or another, and the best operations we have, at least in my 50-day review so far, are those connected with medical schools, whether it be our Palo Alto facility with Stanford, our Durham facility with Duke, our Philadelphia facility with Penn, so we want to do more of that, it is really a great way, and we all benefit.

Dr. ROE. I am going to selfishly promote my school, but——

Secretary MCDONALD. And east Tennessee of course.

Dr. ROE. Yeah, it is one of the—it is one of the five top primary care putting doctors in rural areas in the country, so it is——

Secretary MCDONALD. We need that, we need that badly.

Dr. ROE [continuing]. One of the things that we do, and it is one of the things that Mr. Takano was talking about and Dr. Huelskamp talking about, getting people out to rural areas, which is rural America is where I live, and it is a challenge for us.

Secretary MCDONALD. And our veterans just so you know demographically are moving more to rural areas than they are to urban areas, so this situation will only get exacerbated so we need to get ahead of it.

Dr. ROE. Yeah, I think ten percent of my district are veterans, so a big number there.

Dr. CLANCY. So I will just say it is a very strong primary care school as I recall as well, and definitely on the list for a visit.

And we just want to thank you and everyone else for the additional residency slots, because we recognize that we are in tight competition with the private sector in terms of recruiting and hiring, but we think we have got the best mission.

Dr. ROE. I think long term it is a great method to do. I mean just think in 10, 20, 30 years when nobody is even going to know who we were, it will provide benefits for the VA and for the veterans.

Mr. Chairman, I yield back.

The CHAIRMAN. Thank you.

Ms. Brownley.

Ms. BROWNLEY. Thank you, Mr. Chairman, and thank you, Mr. Secretary, for being here. I certainly enjoyed my meeting with you last week and appreciate it very, very much, and I went back to my district and told my veterans you should have hope, I met with you, and I really appreciate your can do and will do leadership style and approach, and particularly your sense of urgency around reforming and changing and making that cultural change, making veterans first within the VA organization. So I am very, very much encouraged.

I think one of the—you know, one of the more global issues I think I wanted to raise with you in this hearing is in the time that I have served on this committee it has been extremely, extremely frustrating getting information from the VA, and I hope, and my dream is that as you move forward and set out a plan for change within the VA that we will all collectively, we as members of this committee, you at the bottom of your organization, and certainly the veterans and the VSOs most importantly, that we all can collectively agree on the direction the organization is going and then set the appropriate outcome measures that we are looking for so that we can again collectively monitor and watch and evaluate the progress as we move forward.

So for me that is, you know, a very essential thing, because it is really the only way that we can tell the American people that we are, you know, that we are on track and we are making progress. So if you could just comment.

Secretary MCDONALD. Yes, ma'am. As we talked I want to be your partner and that is why I am sharing with everyone our Road to Veterans' Day plan for the next 90 days, and as we are renewing our strategic plan, which we are starting as a leadership team this Friday doing, we will share that with you as well.

I know from my confirmation hearing and from talking to the chairman the communications has been a challenge for us, and frankly some of the communications have come to my desk, I have rewritten myself because I have just been totally unhappy with our ownership for the problem, or with our ownership for the issue.

The CHAIRMAN. I want it integrated so that we are saying the same message, but that is not an attempt to centralize. In fact what we talked with the chair about was decentralizing so that you can go to the subject matter expert and get the answer and it doesn't necessarily need to be cleared with one tip of a funnel.

I think what has happened in the past is the organization has done that, they have made everything go through one person, and when you do that it obviously backs things up. And everybody should be capable enough to be able to answer, and of course I would ask your indulgence that you would have to realize that if you got a wrong answer it may be temporary or it may be incompetence, but the person is not trying to deceive you. And we will work together to make sure we clear up any miscommunications.

Ms. BROWNLEY. Thank you for that.

And I am a strong believer in data driven decision making, I think the data is extremely, extremely important. I would—my two cents would be in terms of the data that will be presented to you is trust, but verify. I don't think I have necessarily the confidence of the data that has been presented to us and don't have the confidence there, and in some ways want to just clean the table and start all over again in terms of the data collection, but I know there is—I am sure there is some good data that is there also. But there does need to be——

Secretary MCDONALD. Well, the point is they are getting the right values and the right mission in place and making sure people look at everyone through the lens of veterans.

Step two is getting the right leaders in place, and we are in the process of doing that.

Step three is getting the right culture in place, and then we have got to get the right strategies. Right now we have a group of strategies that frankly no one is working against. They are in the desk drawn somewhere, but if my test is: can I go to the lowest level employee, or in my case I would say the highest level employee, and do they know how their work every day is tying back to caring for veterans? If they don't stop the work.

I had somebody bring to me a binder full of information the other day. I said, well, what is this for? And one binder was a series of reports. And I said, well, I have already seen all this information, let us stop doing it. And so that got rid of a whole bunch of work. Another binder was testimony I gave at the Senate hearing. Why do I need to see my own testimony? Let us stop doing that.

So we have got to stop a bunch of things and then redeploy all of that effort against caring for veterans.

Ms. BROWNLEY. Thank you, my time has expired.

Secretary MCDONALD. Yes, ma'am.

Ms. BROWNLEY. But thank you, and I look forward to working with you, and I yield back.

The CHAIRMAN. Thank you.

Dr. Wenstrup, you are recognized.

Dr. WENSTRUP. Thank you, Mr. Chairman.

Mr. Secretary, it is a pleasure to be with you today and I do thank you publicly for taking on this task.

I benefit from living in the City of Cincinnati where Proctor & Gamble is located and all the great things that you have brought to our community with Proctor & Gamble has benefited so many people.

But as you take on this job there are so many things to consider, and I know it is a monumental task, but it is not one that you are unfamiliar with, and why so many of us for a while have been talking about needing an outside influence, someone from the private sector, because we are talking about acquisitions, cost versus productivity, changing a culture, assuring quality and care as well as access to care, all these things that go into being successful.

And I just want to say I think if there is anyone that can create a brand it is someone who has been at Proctor & Gamble, because that is what you—and not only that, you build trust with that, and that is going to be the key. So if you can build trust in the VA brand in the same way that you have done Tide I think we will be in good shape.

And I appreciate your openness and the ability to work with you every day. Thank you.

Secretary MCDONALD. I look forward to working with you and I appreciate the fact of the commitment of all the members of this committee, which really means a lot to all of us at the VA.

The CHAIRMAN. Ms. Titus.

Ms. TITUS. Thank you, Mr. Chairman.

Mr. Secretary, thank you for being here. There was a lot of enthusiasm when you were appointed and I think anybody who has heard you testify today will certainly have that feeling reinforced and erase any doubts that you are the man for the job. So we appreciate it.

Also thank you for coming by to see me. It meant a lot that you had already taken time to visit Nevada, both our service center in Reno that has had so many problems and the new hospital. It shows that you are really personally vested in that and we appreciate it.

Also it has been nice to hear all my colleagues talk about our bill to create more residencies in the hospitals, and I would just point out again as we talked about in our meeting, that we want to be sure that those residencies don't just go to the big hospitals that already exist, but really go to the places where they are needed. I know Mr. Beto also worked on that and there are areas that are under served and that was the real intent. So we want to be sure they do that.

Also we are very supportive of your notion of reorganizing not just middle management but also the geographic regions, because Las Vegas is in several different areas that just don't really make much sense.

And finally maybe you could share with the committee and for the record some of the things you told me about the new emphasize on women veterans, because they are our silent veterans, they have had serious problems, one in four hospitals doesn't have a gynecologist. I know that is a new priority of yours, which I am very

supportive of and want to work with you on, and maybe just put on the record some of the things that you are doing that.

Secretary MCDONALD. Yes, ma'am. Well, thank you very much, and we look forward to working with you.

I know that—I know that apportioning those additional residencies will be very important and we will work with you on that, because we have got to—I have played hockey, we have got to go to where the puck is going to go rather than where it has been, and so we have got to—we have got to get after that, and we will work with you on that so we are making a decision together.

Relative to women veterans, to me this is critically important. Right now we have about 11 percent of veterans or women, but of course the percentage in the army—or in the armed forces is much, much higher, so obviously it is going to increase over times.

Many of our facilities were built in the 1950s when we were virtually a single gender army, and so when you think about the kinds of equipment we have, when you think about the kind of doctors we have, you are right, we need to hire more OBGYNs. We have got to get ahead of this, because it is quickly becoming an issue for us already.

One of the things that we have also done is many people see the mission of VA as articulated in Abraham Lincoln's second inaugural address where he said, for him who have borne the battle for his widow and his orphan, and we have changed that, we have paraphrased it, and if you look at our mission the way we call it out here in our 90-day plan we say, better serve and care for those who have borne the battle for their families and their survivors. And while that seems like a modest change in words, it has meant a lot to our female veterans to know that we are looking out for them or we are thinking about them, and we have got to get ahead of the things we need to do so that we are able to meet the capacity.

Maybe Dr. Clancy can talk a little bit more about this, because I know this is of particular interest—area of interest to her.

Dr. CLANCY. I would agree with everything the secretary just said, and it is a very high priority for us, and it has changed a lot in recent years, but we are not going to slow down until every single facility has got a topnotch women's health coordinator.

All of our health coordinators across the system just got reinforcement of all the training that they get to make sure that we are meeting those needs, and it will remain a high priority.

So thank you for your continued support, because we can see where the numbers are going as the secretary just noted.

The CHAIRMAN. Mr. Jolly.

Mr. JOLLY. Thank you, Mr. Chairman.

Mr. Secretary, welcome, we haven't had an opportunity to meet. I echo my colleagues' comments, thank you for serving.

Secretary MCDONALD. Thank you, I look forward to getting together with you soon.

Mr. JOLLY. My predecessor was here for 43 years and one of your predecessors once nominated he counseled, he said, please don't take this job, you are not going to be able to change the VA, and I will never forget that as a young staffer in that meeting, and I know this challenge that you face.

I appreciate your comments today. I want to express a little bit of concern and maybe give you an opportunity to revisit your exchange with by colleague, Mr. Lamborn when he asked about whether you believe that wait lists contributed to the deaths of veterans. I understand that is a hard question for you to ask, but if we are talking about changing the culture it is a very important one, because you have spoken a lot of organizational changes, but as you step into this role do you believe that the negligence of the VA has contributed to the deaths of veterans over the past several years?

Secretary MCDONALD. Again, I think it is very simple, there are veterans who haven't had access, there are veterans who haven't gotten proper care, I don't really need to go any further than that.

Mr. JOLLY. Well, no——

Secretary MCDONALD. That says there is a problem. That says I have got to get it down. I am focused on our veterans.

Mr. JOLLY. Sir, I mean this very respectfully, I got a little heated in the last exchange, I shouldn't have.

Secretary MCDONALD. What value is there in having this discussion?

Mr. JOLLY. Because that actually speaks——

Secretary MCDONALD. Is it going to help more veterans?

Mr. JOLLY [continuing]. Because that actually speaks to the cultural change of the department. I understand the administrative changes and the organizational changes and I think it is needed.

Deputy Sloan Gibson—Deputy Secretary Sloan Gibson when he was acting sat there and apologized to the Congress and the American people for the failures of the department and what it led to for veterans.

You got into an exchange with Mr. Lamborn and you just did now as well that doesn't show an acknowledgment, and to me that is not a cultural change, that is going backwards.

I understand nobody wants this on their fingertips, you weren't there, I get that, I am not holding you accountable. But in terms of the culture that you bring to the top leadership posts at the VA do you believe with conviction that the wait list problem contributed to the deaths of veterans or do you not?

Secretary MCDONALD. Sir, in my opening statement I said I apologize on behalf of myself and the Veterans Administration—Veterans Affairs Department. I have said that in every testimony I have given.

Mr. JOLLY. Right.

Secretary MCDONALD. I have said that when I have gone out to town hall meetings when I have talked to veterans. I own this. It is not because I wasn't there, I own this. I wouldn't have taken this job if I thought that somehow I could not own this. I own this and I am committing to you that I am going to fix it. I don't know that you can ask for a bigger commitment than that.

Mr. JOLLY. Well, I mean it is a very simple question, I am just asking you to acknowledge that the wait list and the negligence that the VA contributed to the deaths of veterans that we have had hearings on for six months, that is all.

Secretary MCDONALD. And I am acknowledging—I am acknowledging that I own it, that they didn't get the proper care, and that we need to improve.

Mr. JOLLY. Okay. Well——

Secretary MCDONALD. And that not getting proper care has adverse effects.

Mr. JOLLY. And I very respectfully will take that as an answer. I don't think it is a complete answer, I don't think it is an acknowledgment of a cultural change that you continue to espouse, but I understand why you need to guard your words carefully in a public hearing and in front of the press, and hopefully privately you acknowledge that the negligence of the VA has led to the deaths of veterans.

Secretary MCDONALD. Let me again say I own this problem.

Mr. JOLLY. I understand.

Secretary MCDONALD. And one of the things my West Point classmate I thought did so well, and he is a great leader as the interim secretary, is he owned it and he is helping the organization own it and I am too. We have to own it. If we don't own it, as you have said, we can't change.

Mr. JOLLY. And I appreciate that. I look forward to working with you. Thank you for serving, I appreciate it.

The CHAIRMAN. Ms. Kirkpatrick.

Ms. KIRKPATRICK. Thank you, Mr. Chairman.

Mr. Secretary, first of all thank you for taking the job, and then thank you for visiting the Phoenix facility as your first stop after you were confirmed, that really gave a message to our veterans in Arizona that you care and you are paying attention.

Now this—I want to focus on accountability, because our committee has heard from people who say they are getting excellent care at the VA and that the employees at the VA care about veterans, many of them are veterans, but I am sure that you are familiar with the business motto, if you will, that an organization is only as good as its weakness link, and we know that there are weak links in the VA. And I just want to get your thoughts about how you insure that there is continuing accountability, and I just want to tell you some of the ideas that we are heard, and then if you could comment on them.

One is rolling audits, review by a neutral party. Mr. Michaud has an idea about setting up a blue ribbon committee that would develop a strategy for the VA. I have a veteran in Flagstaff who talks with me frequently about the idea of a volunteer board of veterans who really don't have any connection with the administration at all but are sort of a sounding board and a way to solve this. I have one idea I introduced by Whistleblower Protection Act, which includes an anonymous hotline for patients and employees to report things. And would you just give us your thoughts about that?

Secretary MCDONALD. Well, I think accountability is a huge issue, and it has got to be a big part of the cultural change.

One of the things we have done is we have talked a lot of about it, we have talked about that concept that I mentioned in my prepared remarks, sustainable accountability. It is not just about firing people, it is about giving day-to-day feedback.

I mean my standard is that an individual would never need to be fired unless it was an egregious activity because you are providing day-to-day feedback so that person should never be surprised. That should be the standard.

Relative to external groups we—Deputy Secretary Gibson when he was interim secretary hired Jonathan Perlin who was the chief medical officer of HCA to join us in developing the blueprint for excellence for the hospital network. That was an attempt to bring outside benchmarking into VA. We are very much in favor of that. The new bill provides for a commission which we will help stand up.

There also is—I am trying to rejuvenate some of the 23 different standing committees we have which are supposed to help the secretary. There are 23 of them, one could argue maybe that is too many, but there are 23 of them that are supposed to be helping the secretary. I want to reenergize those and I want to get the right people on them. One of them Dr. Clancy and I are in the process of hiring new doctors and nurses and clinicians to help us to join that.

So we want to do exactly what you are saying, but the most important thing for me is we have got to get every single employee in the organization to feel accountable for the outcomes of that veteran rather than worrying about the internal workings of VA.

Ms. KIRKPATRICK. And let me just mention one of the more troubling things that our committee has heard, and that is bonuses and that people who perform poorly still get their bonus and that there is this sense of a bonus is an entitlement to the employees, and what is your plan to address that? Can you give us your idea about that problem and what is the—a good use of the bonuses?

Secretary MCDONALD. All right. Well, first of all, Deputy Secretary Gibson when he was interim secretary took the immediate step of the rescinding the bonuses for 2014.

Second of all he took the 14-day metric out of peoples' performance plans because that was helping to cause people to behave in the wrong way based on outcome for veterans.

Third thing is I have gone back and I have reviewed what can we do about bonuses? In private sector there is something called a claw-back provision so that if an individual receives a bonus and you later discover, because we have 100 investigations going on, you can claw back past bonuses in order to do that, and many audit committees, which I have served on, have put rules in place to do that.

In the government right now there is not a potential for clawback because apparently when the law was written the law was written in such a way that when the political parties changed you didn't want to allow the new political party to clawback from the past political party. I have got to get into this in more detail, but that is the way I understand it right now, but that is the practice in the private sector.

Ms. KIRKPATRICK. Thank you, Mr. Secretary, we look forward to working with you.

Secretary MCDONALD. I look forward to it too. Thank you.

The CHAIRMAN. Mr. Secretary, I will tell you that there is a bill that has been filed, H.R. 5094 and it allows you to do just that

should we be allowed to pass that through the full house and then on to the Senate.

Mr. O'Rourke you are recognized.

Mr. O'ROURKE. Thank you, Mr. Chairman.

Mr. Secretary, I want to join all my colleagues in thanking you for your service and taking on this very difficult but not impossible task of bringing the VA back up to where it should be.

And I want to thank you for meeting with me and just from that meeting and some of the issues we discussed in your follow up to those items, including an email today from Dr. Clancy, I think that speaks very well of your ownership of these issues, your attitude of accountability, and some of the things that we will have to look forward to on the bigger issues confronting the VA.

I also appreciate your commitment in our meetings to insure that El Paso, which is currently I would argue one of the worst, if not the worst, operations in the VA become it is model. I think you have no greater opportunity to demonstrate turnaround than you do in El Paso.

And I wanted to use the example in El Paso to make a larger point about the system and get your response. Following what we learned about El Paso, despite our assurances from the VA to the contrary that we were seeing people within 14 days, we learned that fully one-third of veterans couldn't get in to see a mental healthcare appointment, the average wait time you could get in was 71 days, that average appointment when scheduled was canceled at least once on average or rescheduled at least once.

When we had the VHA audit in the spring we learned that we were the worst for established mental healthcare appointments, worst in terms of being able to see a doctor or provider, fourth worst for new patients, second worst for specialty care, on and on and on. So we had that attention, that focus.

VA committed $5.2 million in additional funds. The acting secretary, Sloan Gibson, visited the VA. We had our chairman, Chairman Miller visited the VA in El Paso. We had Mr. Matkovsky visit the VA. We had primary care teams, mental healthcare teams that you sent down there.

And yet when I went there two weeks ago, and I often go by just to talk to veterans and see how things are doing, greet them in the parking lot, I met a number of people who said, hey, I got excellent care, wonderful treatment, thumbs up, you guys are doing a great job, and a number of people who had complications or issues and we tried to help them with them, but one was very glaring to me, and it was a gentleman who said, you know, I was given an appointment today and that was months back that I scheduled it, I called yesterday to confirm my appointment with Dr. B, this is a mental healthcare provider, and they said, yes, we have got you there to see Dr. B at 1 o'clock tomorrow, we look forward to seeing you.

The gentleman shows up, and I don't know how hard it was for him to travel there, but he gets to the VA, shows up for his 1 o'clock appointment to be informed that Dr. B no longer works at the VA and hasn't worked there for a month.

And so I thought with all of the attention that I have been bringing to this issue, that the VA has been bringing to this issue, for

us to fail this veteran that badly is indicative of some deeper, larger issue. And I think of the 20 IG reports since 2005 that we have had about scheduling problems within the VA that all of us, Congress, and administration have known about, and yet we haven't resolved those issues.

Tell me, to Mr. Jolly, and others who brought up this point, answer that concern that we have about culture. We can as we did in El Paso throw money and attention at it, personnel, flexibility in how you fire and hire people, but I think there is a deeper cultural issue. How will you address that in a minute and a half?

Secretary MCDONALD. As I said, cultural change is very difficult to achieve, but it starts with the mission and the values, and I would wonder in an organization have they really committed themselves to the mission and the values if an individual can be signed up for an appointment with a doctor that doesn't exist?

Frankly in a situation like this let us know, we will go back and check and we will get back to you and find out what happened in the specific instance. Any specific anecdotes you can provide us are very helpful, because it allows us to go back and understand what really went wrong and then correct it in the future. So it starts with the mission and values.

Secondly, I think it starts with leadership behavior, and that is why I have gotten out to as many places as I have. I have to get to El Paso.

Third, I think there is a big issue in the openness or lack of openness in this organization. I mean how could you have a situation where employees were lying to one of the most honorable men I have every known in my life in General Shinseki? Why would that exist? Why would that happen? Why would we have meetings where union leadership wasn't involved or weren't invited? Why would we have people feeling their only recourse was to be a legal whistleblower? You know, that is why I demand the town hall meetings, and when it demanded them some of the feedback I got was, well, we can't hold a town hall meeting, it will be counterproductive, it will be violent, whatever. That is exactly why we have to do them.

We have got to open the culture up, we have got to get communication moving, we have got to get ownership for the problems, and we have got to get people feeling responsible. Because in the end the only thing that matters is the veteran. This is going to take time, but we are going to build it into our strategies.

When I think of a high-performance organization it starts with mission and values, and I think we have got that, we are under way there. We have got to look at our leadership and see do we have the leadership to create this new culture? If a leader is unwilling to embrace this new culture then they shouldn't go on the journey with us. Do we have the right strategies in place in order to perpetrate this culture to make it happen across? And we are taking a look at that. Do we have the right systems in place? The system would be so that if you asked me how could this happen in the scheduling system that this doctor who doesn't even work there gets made an appointment.

And then the last is do we have the right high-performance culture where people flow to the work and people work on veterans'

issues? It is going to take time. It is going to take time. But I really do believe we can do it.

Mr. O'ROURKE. As I yield back to the chair let me just offer my assistance. If you are missing legislative authority to do any of the things that you are talking about doing to turn around and improve the culture at the VA I hope that you will come to us as quickly as you know that. We will be your partner in offering that legislation and getting it passed.

So, thank you again for your service.

Secretary MCDONALD. Thank you very much.

Mr. O'ROURKE. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Walz.

Mr. WALZ. Thank you, chairman, and thank you, Mr. Secretary again to assuming this sacred trust and awesome responsibility. I am grateful you are there. I think restoring that trust is one of the first and paramount things.

And I also want to say you scored big points with my chief of staff who is a Minnesota hockey player with your reference. I often as a football coach talk about pursuit angles, but it is the same thing, where do we need to anticipate?

And I have been saying, and I applaud other members and Mr. Michaud for his take, I have been saying for a long time I never understood as a military person myself why there was no equivalent of the quadrennial defense review? Secretary Hagel has that his dispense and I was just thinking about this, think to not have that and defend. I went back and looked at the 1971 under then Secretary Cohen talking about—1997, think about that, we are dramatically safer than during the Cold War, but wild card threats are more than likely to happen, and they started anticipating where those threats would come from once the full out eastern European threat was gone or whatever, that allowed us to start tailoring the force to be prepared to respond to those things. The VA does not have that. The VA did not do that. And here we are trying to figure out that we are going to add a whole bunch of veterans are Iraq and Afghanistan.

So, I would encourage you whatever that form looks like, Mr. Michaud and others are doing this, this is something that would help you enculturate this need to get that there is it would give you that guiding document and it would force us to go back on a periodic basic, whether it is quadrennial or whatever it would be, to get that done. So, I would encourage you to do that.

And then I would say you are at a unique perspective here, this is the time as I have been saying, let us think big, let us do the reforms that have stymied people, let us breakthrough the barriers that have been there, let us crush this thing.

And you know what, it is going to be hard to change cultural, it is going to be difficult, but here is what I would say is, if not you, who? If not us, who then? And if not now, when is this ever going happen? And if the country believes that is important, as I know they do, if all of us in this room believe it is important, let us get there.

And I think something you can bring, and I would just be interested to hear your thoughts, Mr. Secretary, we have got to break down this false construct of government versus the private sector.

We work together best, this is service of veterans, if the private sector can deliver, if we can work in conjunction, if you can do it quit that argument that a dead-end that it is trying to find versus them. This is our veterans trying to get it right.

So, I would ask you how do we speed collaboration? I represent the Mayo Clinic, a great medical institution, but also in a rural area that has roots in combat medicine and that. How can you bring your experience from P&G to bridge that and break down this ridiculous us versus them argument on the care of our veterans?

Secretary MCDONALD. Well, we are going to embrace it in our strategies. We believe that we can't do this by ourselves and that we have to partner. We have to partner with medical schools as we have already talked, we have to partner in the private sector, we have to partner with members of Congress. And so the important thing for us will be to figure out everybody's role and to create a system which takes advantage of that.

I will give you an example. I was in Las Vegas in Congresswoman Titus' district, and there we are very close to Nellis Air Force Base, and the doctors at Nellis Air Force Base can't keep up their medical proficiency without seeing VA patients, they just don't get enough—a broad enough piece of work doing only flight physicals for pilots at Nellis. So it is great. We have the DoD doctors come over to the VA, they serve our clientele, the doctors at Nellis love it, we love it.

So one of the things I did in preparation for this—not this hearing—but for this role, was to get a map of all the federal facilities in the country, I know most of the private facilities because we had a healthcare business at Proctor & Gamble, and to figure out what is the right combination where if we don't have those OBGYNs that Carolyn and I talked about we can—we can borrow them from someone elsewhere—or DoD, Indian Health Service is another example in rural areas. Indian Health Service has some terrific facilities.

So these are the kinds of things that we want to do, and our strategic work is to figure out what is the right combination of these things and inherently it will be local. I mean the details will be in each locale trying to figure out what the right combination is, because it will probably be different.

Mr. WALZ. Well, I would echo Mr. O'Rourke said, if there is something we can do, whether it is credentialing or whatever the things that—I mean some of these things are difficult and they are deep and they are tough, I understand that, but let us get there.

But I want to give an example to my colleagues where I too have been frustrated with some of the flow of information, but I recognize the incredible work that gets down at times. If this is a glimmer of the potential last week in Minneapolis a whistleblower, the press was reporting a story, we were in contact with them, we have been working with this. This happened on a Friday night and by Monday there were people out there on the ground addressing or attempting to address on this, and there was a real sense of collaboration with both the public, the veterans, the member of Congress, all of are working together, where was the gap, where can we fill the gap, and how do we fix it?

So, I have to say I am seeing that and I very much appreciate that I was seen as a partner trying to fix this as was the press as was the whistleblower in the case, and we will see what goes forward. Because I am with you, Mr. Secretary, we can't be afraid to point out our failings, we cannot be afraid to continue to move forward.

Secretary MCDONALD. No, sir, and if any member of the committee ever senses that they are being treated as an adversary I would like to know that, because we know that we need to partner with you to make these changes.

Mr. WALZ. I appreciate it.

I yield back. Thank you, Chairman.

The CHAIRMAN. Thank you very much, Mr. Secretary for being here. We are very appreciative as has been said over and over again that you would be willing to stand in the gap for those who need leadership, and again, we would reiterate that it is our desire to stand with you as a full partner in serving those who have worn the uniform of this company.

Mr. Michaud, do you have a closing?

Mr. MICHAUD. No, I do want to thank Mr. Secretary for coming here, I look forward to working with you, and I agree with everything that Chairman Miller has just said. So thank you very much for your service and look for ward to a strong partnership.

Secretary MCDONALD. Thank you, I look forward to working with you all, and I know every person in VA does as well.

The CHAIRMAN. Thank you, Mr. Secretary.

Secretary MCDONALD. Thank you.

The CHAIRMAN. Member, we have—the votes have been called, and it looks like it is going to be a series that will last about 50 minutes. It is your—5–0—it is your choice. We can begin with the third panel, they have no opening statement so we can monitor the clock and carry on if you wish.

Okay, if we could ask the second—or third panel to come forward. Thank you, as the third and final panel comes to the witness table and we are setting up the name plates I will tell you who we are going to hear from. Dr. Lisa Thomas, Chief of Staff of the Veterans Health Administration. Dr. Thomas is accompanied by Dr. Darren Deering, Chief of Staff of the Phoenix VA.

If you would I would ask you to stand, I was going try and catch you before you sat down, raise your right hand.

[Witnesses sworn.]

The CHAIRMAN. Thank you. And let the record show that both witnesses responded in the affirmative.

Secretary McDonald has already provided an opening statement on behalf of the Department of Veterans Affairs, so we will move directly into a round of questions.

DR. THOMAS AND DR. DEERING ARE JOINING THE PANEL

Dr. Thomas, on March 14th of 2013, the ONI Committee revealed wait time in healthcare delays in Augusta, Georgia; Columbia, South Carolina; and Dallas, Texas. Who months later in May, VA waived the fiscal year 2013 annual requirement for facility director to certify compliance with VA policy further reducing ac-

countability over wait time, data integrity, and the scheduling practices.

Are you familiar with that?

Dr. THOMAS. Yes, sir. I am.

The CHAIRMAN. Did you approve or recommend the waiver of the requirement?

Dr. THOMAS. No, I did not.

The CHAIRMAN. So you knew the waiver was given?

Dr. THOMAS. After the fact.

The CHAIRMAN. After the fact, and what action did you take after the fact recognizing that there was a real problem?

Dr. THOMAS. In the spring of this year is when we realized that we really missed the boat in VHA, that the situations regarding delays in care were more of a systemic issue, rather than looking at each case individually. And in the spring of this year when we went back and researched it, the memo that you reference that was issued in 2010 was prior to my tenure as the chief of staff, so I went back and looked at that. It was in the media; it was hard not to realize that we had this memo talking about our scheduling problems and the gaming of the system.

And we looked at that in relationship to all of the other issues that were going on around the country and realized, albeit too late, that we had a systemic issue. We should have taken a holistic approach to looking at it, rather than looking at each individual instance in isolation.

The CHAIRMAN. We have the original Inspector General report on Phoenix and we have the one that VA released. I assume that you are aware that there was a crucial change in language made in the executive summary that said the physician whose allegations this committee had carefully verified could not tell the Inspector General the 40 names of the veterans who had died. I think this gave a false impression right up front that the whole matter was untrue.

So my question to you is did you have any idea that language like this was going to be inserted in the IG's report?

Dr. THOMAS. No, I did not.

The CHAIRMAN. Your—let me see if I can find it real quick—according to your fiscal year 2013 performance review, by the way, 500 out of 500 is what you received on your review—perfect, one of your responsibilities as Veteran Health Administration Chief of Staff is being able to identify critical OIG reports that could produce negative media attention and ensure talking points in communication plans are developed before the final report was released to increase the Department's responsiveness.

So could you give the committee a little idea as to how that works?

Dr. THOMAS. Absolutely. Sir, first, what I would like to say is we sincerely apologize to all the veterans. No veteran should have to wait for care and it is unacceptable to us. We did get the IG report in several drafts and at each draft stage of getting a draft, it was our responsibility to make sure that we were putting together an accurate communication plan so that we could then communicate to all of our stakeholders what the IG found, but more importantly, what we were going to do to fix it. We really focus on more of the

edits and looking at what we are going to do in the action plan, than the actual OIG report.

And as Dr. Clancy said, we have a management review service and they are responsible for looking at that and making sure that all the correct subject matter experts look at that report and if there is anything factually that they think needs to be corrected, they provide that information. And what we also do is making sure that all the subject matter experts come together to identify what is the corrective action that is needed so that we can meet the needs of veterans.

The communications folks that report to me were doing that every iteration, and so every iteration of the report we were trying to highlight for them what was the differene from the last report to the next report so that they could accurately and very efficiently get a communication plan together. One of those changes was a change from 28 recommendations to 24. The consolidation of a number of individual recommendations regarding ethics were rolled into one. Highlighting those for them makes it easier for them to be more responsive to have a document that is pulled together so we can communicate to all of our veterans, the public, and the stakeholders what was found and what we are going to do to fix it.

The CHAIRMAN. Okay. I am going to ask you to pause right there.

Members, we need to move to the floor. We have got less than five minutes to get to the vote and we will be back as soon as we can.

[Whereupon, at 4:52 p.m., the committee recessed, to reconvene at 5:36 p.m., the same day.]

The CHAIRMAN. The committee will resume its hearing. Again, we apologize to the witnesses. That will be our final interruption for the day.

Dr. Deering, thank you for attending. I would like to know if you have reached out to any of the whistleblowers about resolving their cases, and if no—if so, how many have you worked with?

Dr. DEERING. I have not personally reached out to the whistleblowers at the Phoenix VA about their specific cases.

The CHAIRMAN. Would that be something that you ordinarily would do or would somebody else do that?

Dr. DEERING. I believe somebody else is working with them on their cases.

The CHAIRMAN. But in a normal course, I mean I understand that Phoenix is somewhat of an anomaly, normally, would you be the one who would reach out to whistleblowers?

Dr. DEERING. Certainly. I mean I have had other employees who have brought up concerns within the organization and I work with them closely to address those. I had an employee just about two weeks ago sent me a message on my personal cell phone saying that she had concerns she would like to discuss. She didn't feel safe talking about them at work and I met her off campus to discuss those issues.

The CHAIRMAN. Has anybody prevented you from talking with whistleblowers or advised you not to talk to them?

Dr. DEERING. No, I have not been advised not to.

The CHAIRMAN. Okay. Of the 293 deaths that were identified by the Office of Inspector General, how many required institutional disclosures?

Dr. DEERING. I don't have that information because I have not reviewed those 293 cases specifically. I would have to crosswalk those to see how many would require institutional disclosures. We are in the process of reviewing the 45 cases that were outlined in the Inspector General's report to see which of those would require institutional disclosure, if necessary.

The CHAIRMAN. You are the chief of staff of the Phoenix healthcare system and you don't know if there are institutional disclosures?

Dr. DEERING. I haven't been provided the specific names of those 293 veterans, sir. I can get the list of names of who we have conducted institutional disclosures on and I don't know if those happen to be on that same list.

The CHAIRMAN. Well, let's go this way. How many institutional disclosures have been made at Phoenix in the last two years?

Dr. DEERING. In the last two years—and I can get that specific number—but it is around six or seven institutional disclosures have been conducted.

The CHAIRMAN. Say that number again.

Dr. DEERING. Somewhere around six or seven.

The CHAIRMAN. Okay. Did you order OIG report case number seven's schedule an appointment with primary care consult to be removed from his chart?

Dr. DEERING. Can you repeat that question for me? I am sorry.

The CHAIRMAN. Report case number seven, which was in the OIG report, there was a schedule an appointment with primary care, but it was removed from a chart, and my question is: Did you remove this from his chart or if you didn't, who did?

Dr. DEERING. I don't recall instructing anyone to remove a consult from someone's chart, but specifically to case number seven, I don't have that patient's demographics. I would have to go back and look at that and get back to you with that information.

The CHAIRMAN. Who at Phoenix can remove those kinds of records or can wipe a chart clean?

Dr. DEERING. Consults typically aren't removed; they are discontinued or cancelled or completed. So even if they are discontinued or cancelled, they would still stay in that veteran's chart and they would show that they were discontinued or cancelled.

The CHAIRMAN. It was a primary care appointment that was taken off of number seven's chart, so, again, I am just trying to get to the bottom and find out exactly what happened.

Dr. Maher is it Hutman? Huttam.

Dr. DEERING. Huttam.

The CHAIRMAN. Huttam.

Dr. DEERING. Huttam, yes.

The CHAIRMAN. Huttam, reported health and patient safety issues to leadership and was fired. I am sure you are aware of his firing and I guess was fired by Ms. Hellman. Did she ask or require you to do a board on Dr. Huttam?

Dr. DEERING. Specifically regarding Dr. Huttam, I don't recall him bringing patient safety concerns to my attention. Regarding

his termination, a summary review board was convened to look at his case specifically and make a recommendation to the medical center director.

The CHAIRMAN. But you did conduct a board on him?

Dr. DEERING. I did not conduct a board. I convened a board and it was ran by another physician.

The CHAIRMAN. Can I ask you—it is a personal question, but I think it is pretty simple—after all that has happened at the Phoenix VA medical facility, how is it that you are still employed there?

Dr. DEERING. Sir, I think that is a fair question, and if I may, I grew up in the VA. My father, who was a veteran and passed away in October received all of his care through the VA healthcare system and I have memories from being a child growing up in waiting rooms where we would often show up and wait all day for an appointment, and often be turned away at the end of the day not being seen.

I came to work at the VA after training there as a medical student, as an intern and resident. Dr. Foot was my attending when I was a resident. I am very committed to this mission. I worked one year in the private sector and I ran back to the VA when I had the opportunity. I have committed my whole career and a lot of my personal life to try and improve the VA.

The Phoenix VA is certainly not perfect and I have said that before. I don't think that any healthcare system is perfect. We certainly have made mistakes. We are learning from them and we are moving forward, and a good example is after the interim report came out from the Inspector General, I helped lead the initiative to get all of those patients that were on unofficial lists in for care, contact them and get them in, in a short duration of time.

I am very committed to this mission and to the cause and have spent a large part of my life either as a child growing up or as a trainee or student or as a provider in the system. I believe in the system.

The CHAIRMAN. Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman.

Dr. Thomas, were you aware of VISN's 18 director's report in January of 2012 and again in May, 2013, that found that the Phoenix healthcare system was using unauthorized scheduling practices and not complying with VHA's scheduling policies?

Dr. THOMAS. I was not aware of the report until it was cited in the media and then we asked for a copy of it.

Mr. MICHAUD. Is it your job to ensure that Phoenix complied with the VHA's policies?

Dr. THOMAS. I think it is all of our job in central office to make sure that we have a system that has policies in place that the field can understand, that it can implement, and we do need to improve our oversight to ensure the field is following policy. That is one of the things that both Dr. Clancy and the secretary are looking to change as part of the change in the culture to make sure that we have the appropriate oversight in the central office and the auditing function to make sure that things are happening the way that they are supposed to be.

Mr. MICHAUD. Can you explain to the committee what your job is?

Dr. THOMAS. I can. As the chief of staff, I think the best explanation I can think of is I really serve a function as an advisor to the Under Secretary, whoever that may be, but I am really like an air traffic controller. I don't get to fly any planes. I am not responsible for making sure the plane takes off or lands safely; I am the one who is there to make sure that all of the planes are flying on time, going in the right direction, which is set by the secretary and the under secretary for health. So I need to have a broad understanding of everything that is going on within VHA, but, unfortunately, that means I am not a subject-matter expert. I can't drill down into each one of those areas and know in detail exactly how it works.

Mr. MICHAUD. Okay. So you are looking at the planes as they take off and land properly, since Phoenix, Arizona, was not complying with VHA policy, not complying with it, you set a path for them to follow. They did not follow it. So who is responsible at VHA, is it the under secretary or your job as chief of staff——

Dr. THOMAS. I think——

Mr. MICHAUD [continuing]. Or is your job of chief of staff is to be a—to make sure the secretary doesn't understand what is going on in the VISN office?

Dr. THOMAS. I think it is all of our responsibility in central office. If I could, sir, if you would allow me, when the first panel was here you asked a very important question and you said really what we need to know is what happened; why did it happen; how do we move forward; and how do we hold people accountable?

And I think that is really key. And what did happen was that we have an overly complex scheduling system and process, which we are in the process of fixing. We also have an undue focus on performance metrics, and as you heard the secretary say, all of the performance metrics are related to the wait, the fourteen-day wait time metric has been removed.

We do have capacity issues and the Choice Act which was recently passed is going to help us do that. We are going to hire 9600 clinicians just in fiscal year——

Mr. MICHAUD. Okay. Since my time is running out, I guess the big concern I have—yes, we gotta find out what happened and how are we going to solve the problem, but if you were part of the problem in the under secretary's office that knew that Phoenix, Arizona, and other facilities were not complying with policies that were set by the Department, I guess it is your responsibility, and that is a big concern. I know I have it and I know that other committee members have is if you are part of the problem, how am I going to feel comfortable that you are not still going to be part of the problem?

Dr. THOMAS. Sir, unfortunately, we did not know of the problems in Phoenix until the spring and we did not know of the previous reports that the network had commissioned and saw that they had a problem, and I am not sure where that decision broke down, why we didn't know, but I do know that with a change in culture that the secretary has set forth for us, we are going to remedy that issue.

Mr. MICHAUD. Did you see a problem with the Under Secretary Petzel and Secretary Shinseki, as far as not moving in the same direction or is there undercutting occurring between the two?

Dr. THOMAS. I was very rarely in the same meetings as the two gentlemen. I only knew what I heard the secretary say in the meetings I was in and what the under secretary would say when he would come back from meetings with the secretary. I was not privy to those personal conversations.

Mr. MICHAUD. My last question moving forward is, is there—what—as the VHA Chief of Staff, what have you done to make sure that scheduling problems do not continue to occur?

Dr. THOMAS. We have two very major initiatives that we have taken on. The first one was the audit, the access audit, which I know you have been briefed on so I won't go into detail. But that was very important for us to understand if this was isolated instances around the country or if we had more pervasive systemic issue, and sadly we know today it was a more systemic and pervasive issue.

So we then launched into the accelerating access for care and make sure that we can put resources to all of the veterans who are waiting for care. Anyone who was waiting more than 30 days we contacted. We reached out to every single one of them and offered for them to come in for care earlier or refer them to the community for care.

For those that we could not contact, we made three attempts by phone, we sent a letter, and we are also working with partners trying to see if we can locate those veterans. So we are taking those extra steps to make sure we can identify who they are so we can bring them in for the needed care.

Mr. MICHAUD. Okay. And last question—I know I am a little over time, Mr. Chairman—but do you think that there is too much autonomy at the VISN level and that is part of the problem, as far as following the directive from the Secretary or Under Secretary of Health?

Dr. THOMAS. My personal opinion is that we are not well-standardized. A lot of people talk about centralization/decentralization; I think that is the wrong conversation. I think we need to have a standardized system of healthcare that we can consistently provide quality healthcare to all of the veterans, whether they are in the large cities or in the rural areas.

Mr. MICHAUD. Thank you, and thank you, Mr. Chairman.

The CHAIRMAN. Mr. Huelskamp, you are recognized.

Dr. HUELSKAMP. Thank you, Mr. Chairman.

I am new on this committee and maybe it is just me, but trying to understand and—what is being reported in the numbers can be very difficult at times. I will note there is at least 41 individuals that you did not reach on the outreach campaign that is reported as deceased, and I will note for the committee I think that is part of the records that did not get reviewed by the OIG where those—at least those 43.

One thing I want to bring attention to that is disturbing to me is, Dr. Thomas and Dr. Deering, we have student rosters including employees from Dr. Deering's office, emails on VA purchases ap-

proved by the VISN and VA-sponsored training using a book called, "How to lie with statistics."

And the author explains that his book is primarily used in the way to use statistics to deceive and a well-wrapped statistic is better than the big lie because it misleads you and it cannot be pinned on you. One of the techniques described in this book—and this is again, techniques that are taught in a course for VA employees—but I think it might have been used here before the committee. On July 11th, this was a chart provided to us by, I believe Dr. Deering's office or folks out of Phoenix, that led the committee, I believe, to suggest well, we have a problem with not enough employees.

And if you look at the blue, you say, oh my goodness, look at the increase of the number of visits and needs of patients and the green line is the number of the FTEs increased, but when you put the two charts together, you will find out that they are on different scales and they are about flat. They are about even. This is about equal growth if you pull those numbers out there. But I look at that and the average American looks at that and says, oh my gosh, we just didn't spend enough money or didn't have enough employees there.

But I think it is pretty clear. You can look at this graphic. You pull it down, and you look at what your employees are learning from in a book in the courses and my question of this probably to Dr. Deering or Dr. Thomas, but who orchestrated what appears to be a purposeful intent to deceive veterans, Congress, and the American people?

Dr. Deering.

Dr. DEERING. Well, regarding the book, that, from what I recall, that was actually a VISN-sponsored training for coaching sessions. I wasn't involved with purchasing that book.

The graph that you are showing on the screen right now is part of our congressional briefing to our local delegates. There was no intent there to mislead anyone. We were trying to basically outline the framework of how we got to where we were in Phoenix as part of Mr. Michaud's question.

Dr. HUELSKAMP. Well, why would you do two different scales and put those together. I think that is very misleading, because if you actually use the same scale, the growth in the FTEs and the number of visits is about the same.

Dr. DEERING. I appreciate that feedback. The intent was not to mislead. The——

Dr. HUELSKAMP. What is the intent to show there?

Dr. DEERING. The intent to show here is we have had continued growth in the outpatient setting on a number of visits that are coming into our facility over the last several years, and when you look at the increase in the FTE, it has gone up a little bit, but the key point here was back in fiscal year 2010, my personal belief is that we still, at that point, we did not have enough personnel to meet the needs. We were in the process of trying to hire staffing and get people on board.

Dr. HUELSKAMP. But why would your employees be learning from a book about how to lie with statistics?

Dr. DEERING. Sir, I can't speak to that. That is a title of a book. I don't—I don't——

Dr. HUELSKAMP. Well, there are employees from your office, I believe that are learning from this course. And so you have never seen this book before?

Dr. DEERING. I have seen the book. I haven't read it.

Dr. HUELSKAMP. Are you saying that your employees have the book and are using it?

Dr. DEERING. I don't know which employees would have that.

Dr. HUELSKAMP. Okay. Well, where did you see the book?

Dr. DEERING. I saw the book when the coaching session happened. This was quite a long time ago.

Dr. HUELSKAMP. But I don't understand. What is a coaching session? You are coaching them to use this book to mislead the public?

Dr. DEERING. No, not at all, sir. Not at all, sir.

Dr. HUELSKAMP. Well, describe why you would use a book like this which, again, demonstrates how one can misuse statistics—and I have a background in this, this is part of my Ph.D.—and misuse statistics to mislead folks? Can you describe why would you be coaching people with this book?

Dr. DEERING. I can't speak to that because I wasn't—I didn't coordinate that training session through the VISN, sir, and I don't know if they were trying to teach people how to notice when statistics are not being used appropriately.

Dr. HUELSKAMP. Well, actually, it says how to lie.

Dr. DEERING. Right. So I don't know if the content of that book is teaching people how to notice when people aren't being honest with statistics or if it is teaching people how to lie with statistics. I don't know what the intent of that book is without reading it.

Dr. HUELSKAMP. This is your chart coming from your office——

Dr. DEERING. Yes, I know.

Dr. HUELSKAMP [continuing]. And I think it is very misleading and it is difficult as a policymaker to get to the bottom of the facts of the matter, and we just had a hearing earlier, a few hours ago—you might have been here—but trying to figure out how many folks were on the waiting lists. And the numbers are very confusing coming out of the OIG, but this would suggest that gosh darn it, that there has been enormous growth, but there has not. It is a scheduling problem, and we have heard that again and again from the OIG, as well as from your office and I think that is very misleading.

So, Mr. Chairman, I just want to make certain—I just will say—and I appreciate the time, Mr. Chairman— it is so difficult to follow what the numbers actually are, and we have gone so far as to say the numbers don't matter anymore because it is driving bonuses and I think that both of you have pretty significant bonuses.

Dr. Thomas, you have had bonuses for how many years in a row?

Dr. THOMAS. I don't know, but I would be happy to provide that information. I have the last two years here that I would be happy to leave with you.

Dr. HUELSKAMP. Okay. I think mine show five or six or seven years in a row, and also doing very well.

So with that, Mr. Chairman, I would have to share this with the rest of the committee, let's be very careful with what we see, unless it matches up with reality.

Can you fix up this chart to match up—put on the same scale so we are comparing apples to apples?

Dr. DEERING. Sure, we can do that for you.

The CHAIRMAN. Thank you.

Dr. HUELSKAMP. Thank you.

Ms. Kirkpatrick.

Ms. KIRKPATRICK. Thank you, Mr. Chairman.

Dr. Thomas and Dr. Deering, as you can see, the committee has a lot of whys and since this problem has been brought to our attention, and as Dr. Huelskamp said, we want to get to the facts. And it is not that we want to harass you, but we want to understand the whys in order to craft some policy that makes sense.

And for instance one of my puzzling whys has been this memo of 2010 that outlined all of the scheduling problems, and I just would out of curiosity like to know if either of you or both of you, maybe, saw that memo and what happened next?

Dr. THOMAS. I can answer first, Congresswoman. That memo was signed and distributed prior to my tenure. I believe it was in April of 2010 when that memo was signed and I started in my position in 2011. I did not have awareness of it until we realized what we were having in the spring of this year that we were having significant issues around our system and started doing the research and pulling all the pieces together and became aware of that memo on that.

Ms. KIRKPATRICK. Thank you for that honest answer.

Dr. Deering.

Dr. DEERING. My answer would be very similar. I came into this position in 2012. Prior to that, I worked as an inpatient hospitalist. I ran the inpatient side of the hospital and I didn't work with the outpatient side very much, so I wasn't familiar with that memo, and I didn't become aware of it until this crisis surfaced.

Ms. KIRKPATRICK. You know, that is troubling to us, but at least it is helpful to know, because obviously there is a problem in communication in terms of checklists of things that need to be done and improved.

I appreciate that you are trying to identify the vets who need care and need scheduling. I represent a very large rural district in Arizona and I just want to tell you that the VSOs in my district are very willing to help you identify those veterans, especially on tribal land. So we have vast areas where it is very difficult to reach veterans, but they have reiterated over to me over and over again that they are willing to assist. A lot of them know them personally. We just want to make sure that they got—that they get access to care.

Dr. DEERING. And I am very happy to work with them, as well, to try to connect those veterans to their care.

You know, we were talking earlier about rural health. I grew up in a town of 400 people. The VA saved my father's life. He had melanoma and there was not a dermatologist within probably 60 miles of our home and the local VA was able to leverage teledermatology to get him care in St. Louis and this was in 1992, 1993, so

this was years ago that the VA leveraged that type of tool to get care for my father, so there are resources, and I am more than happy to talk with you afterwards on that.

Ms. KIRKPATRICK. I appreciate that and the VSOs will be very happy to hear that, and I yield back the balance of my time.

The CHAIRMAN. Thank you.

Dr. Deering, prior to your current role, you said that you started in 2012, had you ever been a clinic director of a medical facility?

Dr. DEERING. A director of a medical facility, no; I was the chief of the hospitalist service at our facility and was responsible for the care of the inpatient side of the house.

The CHAIRMAN. Okay. So you have never been a clinic director or service chief of a medical facility?

Dr. DEERING. No, sir.

The CHAIRMAN. Okay, thank you.

Were you aware that scheduling manipulation of any kind was occurring in Phoenix before, really, I guess April 9th when it hit?

Dr. DEERING. When I became chief of staff in 2012 we started working on improving access to the veterans and one of the things that we had learned in that process was that some of our ambulatory care clinics had carved out time during their day to do administrative work instead of patient care, so we systematically started going through that process to standardize the expectations for frontline staff in the clinics. I don't know if I would call it manipulation, but there were certainly some providers who were working very hard seeing a lot of patients and there were some providers who had managed to block out parts of their clinical time to not see as many patients and I don't think that is fair to our veterans. So the expectation would be that we would standardize that across the healthcare system and go through and clean those profiles up for our providers.

And unfortunately or fortunately in the process, some of those providers felt that they did not want to continue the journey with us and they left and others continued to feel like things were being rectified and made more fair in the process and it helped to improve appointment availability for our veterans.

The CHAIRMAN. Are you both aware of the litigation hold that was placed on the Phoenix records?

Dr. DEERING. Yes.

Dr. THOMAS. Yes.

The CHAIRMAN. Have—remember that you are both under oath—have either of you deleted, removed, or made unavailable, any emails related to the scandal in the Phoenix area, any communication at all?

Dr. THOMAS. I have not.

Dr. DEERING. I have not.

The CHAIRMAN. Okay. Dr. Thomas, there was a news report this morning on CBS news—I don't know if you were able to see it—citing a whistleblower in the central office who talked about how VA officials sought to soften the Inspector General Phoenix report, and I want to paraphrase kind of what the whistleblower said. He said that the VA was worried that the IG report was going to damn the organization, which it did, therefore it was important for VA to introduce language that softened the blow.

So my question to you is did you ask or are you aware of any employee in the central office who asked the IG to change the report or questioned the IG about any language, verbiage in the report? I mean there has been a hang-up on specific words and I get that—well, I will let you answer that, yes or no?

Dr. THOMAS. Thank you very much. I am happy that you asked that question. I think it is a very important question. What the IG found——

The CHAIRMAN. No, that would be a yes or no.

Dr. THOMAS. It is a more complex situation than that, sir.

The CHAIRMAN. My question to you is: Yes or no, did you ask for any changes in the verbiage? I know the process——

Dr. THOMAS. I did not.

The CHAIRMAN. Okay. Thank you very much, and I appreciate your doing that under oath.

How did you find out that the verbiage had been changed and what was your reaction when you heard it?

Dr. THOMAS. We saved—as I mentioned earlier, the process is a standard process that we use with the OIG and we get draft reports. We then begin to draft our response in terms of an action plan, as well as any communication products, such as fact sheets and communication plans that need to go along with that.

On one of the iterations of the report, in fact, I do remember the very first report made no mention at all of the 40 deaths. The second or third iteration, a paragraph arose in that new draft. It was a little bit confusing. I am not exactly sure what it was communicating, and then in the final draft that we got—and we were already working our final action plans and every time we submitted something another draft came in—so we would go back and say what is different in this draft so that we can then address it and update our data.

In the last draft that we received, it did have the sentence that is in there in the final report.

The CHAIRMAN. So what was the language that was confusing?

Dr. THOMAS. There was a paragraph in one of the drafts that talked about the number of cases. It mentioned something about the 40. I don't remember off the top of my head exactly what it said, but it talked about the various levels of concern, so many patients this and so many patients that. I'm sure, since you request it from the IG, you'll see those copies and see exactly what it says, but I don't know off the—I can't remember verbatim.

The CHAIRMAN. So the changes were made at about the third iteration?

Dr. THOMAS. Well, there were changes on every iteration of the draft.

The CHAIRMAN. Okay. We are talking about two specific changes. It is my understanding—and I should have asked this of Dr. Day when he was here—but it is given to the—again, I learned today that there are numerous iterations that go back and forth. I thought the IG produced a report, gave it to VA, VA reviewed it for factual issues, and a final report came out.

Now, I understand it that there was a back-and-forth conversation between the Office of Inspector General and I assume you?

Dr. THOMAS. No, sir.

The CHAIRMAN. Who?

Dr. THOMAS. I am sorry, I didn't hear you?

The CHAIRMAN. Who?

Dr. THOMAS. I don't know. I do not know. I just know that I did not have any communication——

The CHAIRMAN. Well, the secretary said in his testimony that he was not a party to the conversation, so as the chief of staff of Veteran Health Administration, you have no idea who was involved?

Dr. THOMAS. I had no direct contact with the IG whatsoever during the process.

The CHAIRMAN. That is not my question. My question is, you have no idea who is involved—I mean your—part of your bonus and your review specifically talks about the OIG reports and the negative impact that they may have and the light that they may show. So you are telling me that you had no communication at all?

Dr. THOMAS. That is correct.

The CHAIRMAN. Okay. Yet you got a—but you got a perfect performance evaluation and a double-digit bonus, yet you weren't involved at all?

Dr. THOMAS. What do you mean I wasn't involved at all? I wasn't involved at all in any direct conversations with the IG about changing any portion of the report. What I was involved with was taking the reports that they submitted to us and making sure that we had a good action plan to correct the issues at hand and to have a communications plan that clearly communicated to the Members of Congress and the public about——

The CHAIRMAN. Okay. And so your action plan, at what point, when apparently there were two statements that were entered into the report that were not in the original, one was that Dr. Foot did not give the 40 names, which, can you tell me why that would need to be——

Dr. THOMAS. I have no idea.

The CHAIRMAN. Yeah? I mean I am just trying to figure out why that would need to be in a report.

And then the other about conclusively cannot, which they have now said they couldn't also say that it didn't cause death. So at what point did you learn that that was in the report?

Dr. THOMAS. When we see the final draft to respond to.

The CHAIRMAN. The final draft?

Dr. THOMAS. Yes.

The CHAIRMAN. Okay. So it wasn't in the third iteration; it was——

Dr. THOMAS. And I am not even clear, sir, on how many iterations there were. I know that I personally saw three.

The CHAIRMAN. I think the OIG said there were five.

Dr. THOMAS. Well, I personally only saw three.

The CHAIRMAN. Okay. So you did see three?

Dr. THOMAS. Yes.

The CHAIRMAN. Okay. Very good.

Thank you for appearing under oath and answering these questions. I appreciate that.

Mr. Michaud.

Mr. MICHAUD. I will set this one out.

The CHAIRMAN. Dr. Huelskamp.

Dr. HUELSKAMP. Thank you, Mr. Chairman.

As I understand the answer to your last question in terms of Dr. Thomas, you saw the iterations, but weren't able to make any amendments? They were just sent to you via email or hard copy and here is what is out there. Can you describe that a little further?

Dr. THOMAS. As with all OIG reports, they are provided to us either on hard copy and/or on email and they are stamped with instructions to guard it and it is only to be used for official purposes. When we receive that, we then work with it. We have, as Dr. Clancy said, an organization within VHA that is responsible for coordinating the effort——

Dr. HUELSKAMP. Is there a distribution—sorry to interrupt you—because I think you answered part of that already. Because if I understood, you had no idea who asked for changes, but you received those adaptations.

Was there an email distribution list or is it blind copied to you?

Dr. THOMAS. No, it went out to a number of people who needed that document.

Dr. HUELSKAMP. Can you describe—can you identify a few of those folks who were receiving that document that needed to?

Dr. THOMAS. I am sorry, I didn't hear the question?

Dr. HUELSKAMP. The other individuals that needed to see the document—I guess yours was view only. You couldn't amend it. You make no suggestions to amend it, but somebody else did?

Dr. THOMAS. It is not view only. It is provided on email so that if we needed to cut and paste some words to be able to put into the action plan, we didn't have to retype it. I understand the concerns of the committee, I really do.

Dr. HUELSKAMP. But my question, though, is who was making the changes? We still don't know. I asked the secretary—well, that is not me that is somebody down there. You seem to be the one at the level and you saw the iterations, but you are telling me from the VA side who suggested changes?

Dr. THOMAS. I do not.

Dr. HUELSKAMP. Okay. Do you know who would know who made the changes?

Dr. THOMAS. I do not.

Dr. HUELSKAMP. Do you know who was on the distribution list? Did you ever see another email? Can you name one other person that received a copy of the drafts?

Dr. THOMAS. I would have to go back and look at my email to see who was on there, because there was a listing on an email, I do recall, saying here is who we sent it to and here is who is getting a hard copy of it because we wanted to limit the distribution on email because of the fact it was such a high-visibility case and that many people would be interested in seeing several of the drafts.

Dr. HUELSKAMP. Well, what happened with the leak, and I can appreciate that concern, but the folks that were looking at or reviewing the draft, were they all in your office?

Dr. THOMAS. No.

Dr. HUELSKAMP. No. Can you identify another office that they might have been from?

Dr. THOMAS. There were members from management review service. There were members from the operations side of the organization. I am sure that the field probably——

Dr. HUELSKAMP. Public relations, did they get a chance to review that?

Dr. THOMAS. Absolutely. Our communications office that reports to me needs those documents. They received each iteration because, as I said, they needed to start working on the communications plan. We needed to work very efficiently and we couldn't wait until something was published and then have them start understanding the report and working on a communications plan.

Dr. HUELSKAMP. Yes. Has a report like this ever been leaked before to your knowledge?

Dr. THOMAS. There are lots of things that are leaked. I don't——

Dr. HUELSKAMP. To your knowledge, has a report like this been leaked before? Do you have any policies against leaking?

Dr. THOMAS. Absolutely.

Dr. HUELSKAMP. If someone is found out to be leaking the document or authorizing it, what is the punishment?

Dr. THOMAS. I think absolutely that they should be held accountable.

Dr. HUELSKAMP. What is the punishment?

Dr. THOMAS. We would have to work with our H.R. experts to find out. It depends upon that individual if they have had prior disciplinary action because we have progressive discipline within the federal government and VA, and so if they have committed prior acts, the discipline that would be proposed for them would be stronger than if it was a first-time offense.

Dr. HUELSKAMP. Dr. Deering, I want to ask you some specific questions, and, again, trying to understand what was going on in Phoenix, if I might. The OIG report identified, for example, 1800 individuals on near. Did you know there were any folks—are you aware that there was a near list?

Dr. DEERING. I was not aware that there was a near list until Chairman Miller brought the concerns up on April 9th and we quickly started trying to peel this back and see what was going on.

Dr. HUELSKAMP. And when did you find out that there were 1800 names on that list?

Dr. DEERING. It was sometime in late April. It was probably two or three weeks, approximately, from what I can recall, after the disclosure of the information from Chairman Miller.

Dr. HUELSKAMP. Okay. The other thing that is—there is a lot of things in here, these urology consults, the numerous other 600 printouts. When did you become aware that some member of staff was printing out a scheduling request and sticking it in a folder, when did you find out that was going on?

Dr. DEERING. Around the same time that I found out about the near report.

Dr. HUELSKAMP. Okay. And what did you do about it then once you discovered that that was occurring, and would it be your responsibility to take care of this or is it somebody else's job?

Dr. DEERING. Yeah, so my role as a chief of staff at the facility level is a little bit different than Dr. Thomas. At the facility level, the chief of staff is responsible for the physicians and the clinical

side of the house. The scheduling process that you are referring to falls under more of the business side of the house, so those were not my employees. I cannot really speak to what happened with those employees, but I do know that they quickly put a stop to that process and started educating staff about the—those employees about the correct process to schedule patients.

Dr. HUELSKAMP. Well, there is actually ten years of OIG reports of the scheduling practices, so there was no quick stoppage to it. There might have been about this one once it hit the fan, but that is a real concern as well, as it has been going on. I mean those reports were out there in public for years before you took the job, so I was just curious what had happened with those.

Again, I am not sure what the numbers—as I stated earlier to some Members of the Committee—of unreviewed documents and files, and it could have been anywhere from three to four to five thousand. It was very unclear from the OIG report, Mr. Chairman.

So thank you for the time. I yield back.

The CHAIRMAN. Ms. Kirkpatrick.

Ms. KIRKPATRICK. Thank you, Mr. Chairman.

Dr. Thomas, we have all been concerned about the antiquated IT system and you stated that it is an overly complex scheduling system and you are in the process of fixing that. I just want to know what that entails, what you are looking at and just give me some—an update on that process.

Dr. THOMAS. Absolutely, Congresswoman. I think there are two components to that. The first is our policy. We need to have a clear policy that is easily understood by all of our employees that they can follow. The second component would be the system, the IT system to allow us to do that. I do know that just recently we did a call out to the field to make it easier for our schedulers and offered each one of them dual screens because of the IT system that they are currently using, it would make it easier for them to do their job to have multiple monitors.

We are doing interim updates and fixes to our current scheduling system while we do a more long-term solution which we have had an industry day lately in trying—just recently—in trying to get an off-the-shelf solution for our scheduling concerns.

Ms. KIRKPATRICK. Do you have any idea of your timeline for that, when you think that you'll be able to get an off-the-shelf system and really bring it back into the 21st century?

Dr. THOMAS. I should know that. I sit in the daily briefings that we have on this topic and we brief the schedule once a week, but I cannot think of that off the top of my head. I would be happy to get that information for you.

Ms. KIRKPATRICK. That is fine. Thank you.

I yield back the balance of my time.

The CHAIRMAN. Mr. Michaud.

Mr. MICHAUD. Yeah. Dr. Thomas, you said that you looked at three of the draft reports. Did you provide any input to the IG, either directly or through another staff person, to the IG as far as changing that report?

Dr. THOMAS. I did not.

Mr. MICHAUD. Why—you are the chief of staff, and particularly with this particular case, the level of publicity that it has received, why did you not look at all five of the reports?

Dr. THOMAS. I don't think I had an awareness of all five of them. In preparation for this hearing, obviously, I went back and looked through the history of what I saw and when I saw it and what I looked at in my in-box and what I have reviewed were, I could see the interim report and three drafts of the final.

Mr. MICHAUD. So you made no comment to anyone else at VA, as far as the report and changes you would like to see in it to VA employees?

Dr. THOMAS. We had plenty of conversations about the report. I think that when the first draft came out, we were all quite surprised that there was no mention of the 40 deaths, but we—I, personally, made absolutely no attempt whatsoever to intervene or change that. It seemed quite odd since that was what was in the news, as the IG had mentioned, all over the news and we personally have answered questions of our neighbors and our families of, you work for the VA, did you kill 40 people? That is what people thought, but that is not the most important part of that IG report.

The most important part is that it identified that we have delays in care and problems with coordination and that is what we have to fix. I personally was interested that the report should address the 40 deaths because my concern was that the veterans would not have faith in their healthcare system and they need to be able to come to us for care if they needed healthcare.

Mr. MICHAUD. Now, when you had mentioned—you just said "that we"—I guess the part that concerns me is that you are the chief of staff and particularly this case has got a lot of news and I think we do have to move forward, but we are trying to get back to where the disconnect is. And when you mention "we," who is the "we"?

Dr. THOMAS. I said "we" and then I corrected myself to I, because I am under oath and I can only speak to myself.

Mr. MICHAUD. But who did you talk with within the Department?

Dr. THOMAS. I think there were—I know that there were multiple meetings within VHA, with leadership, with communication staff, with the congressional folks, both within VHA and—I mean it was a topic. It was in the news and we were waiting with bated breath to get the report to see what did it say because we did take immediate action right after the interim report and we wanted to know where else are we falling short where we are not providing quality care to veterans. We need to get our act together to fix it. We wanted the report to see what else do we need to put in place.

Mr. MICHAUD. Is that we, Dr. Petzel? Is the we, Secretary Shinseki? Or is the we, some staff below you?

Dr. THOMAS. I think collectively everybody in the Department. We have over 300,000 employees in VHA and I am sure almost every single one of them gets up every single day to make a difference for veterans, just as I do, and we don't come to work to try to mislead or hide or obfuscate anything.

Mr. MICHAUD. Yeah, I realize that you have that many employees, but when you said that "we discussed the report," I am sure

you didn't discuss that report with the 300,000 employees, so I was just trying to narrow down the "we" that you were talking about. And I know that being the chief of staff that you, oh, that is your job, but it is a very important job, and you set the tone, as well as the Under Secretary, so I do have a concern with some of your answers today. But with that, Mr. Chairman, I yield back.

The CHAIRMAN. I have one final question. Dr. Thomas, who do you believe commissioned this OIG report?

Dr. THOMAS. I believe that the OIG report was initially started because of a hotline call out from a physician from Phoenix and that after the April 9th hearing that the IG was directed to do so.

The CHAIRMAN. By who?

Dr. THOMAS. I believe Congress charged them with investigating the issue. It is my belief, I could be wrong.

The CHAIRMAN. No, you are correct.

Dr. THOMAS. Okay.

The CHAIRMAN. And so my question is, how is it that you got the final report before Congress got it?

Dr. THOMAS. The final draft?

The CHAIRMAN. The final report.

Dr. THOMAS. I did not get the final report.

The CHAIRMAN. Final draft. Call it a draft. Call it a report. How did you get—how did you see the final copy, whatever it was—how—if you saw the final draft, you saw the final report. How did you see it before Congress?

Dr. THOMAS. I am sorry. I don't know when Congress got it. I know the report was publicly released on, I believe August 26th and we see the final draft because we have to respond to it before it is published.

The CHAIRMAN. Okay. Well, it has been your testimony, both of you, that neither one of you knew that any of this was happening; is that correct?

Dr. THOMAS. Can you be more specific in your question, sir, any of what was happening?

The CHAIRMAN. Oh, I don't know, manipulation of data, problems with scheduling, any issues with delays in care. You weren't aware of any?

Dr. THOMAS. In the spring.

The CHAIRMAN. But you came to work in July of 2011?

Dr. THOMAS. 2011.

The CHAIRMAN. And so you weren't aware of any delays in care until April 9th of 2014?

Dr. THOMAS. As I said when I started this hearing, sir, I think VHA missed the boat. We were getting——

The CHAIRMAN. No, I am talking about you individually.

Dr. THOMAS [continuing]. Individual reports from the IG.

The CHAIRMAN. I am sorry, I am talking about you personally.

Dr. THOMAS. And I am a member of VHA and a team that wants to provide excellent care to veterans.

The CHAIRMAN. You are telling me that you were not aware of any of the problems until the hearing on April 9th?

Dr. THOMAS. What I am trying to explain is that as the situation arises, we were looking at that as an isolated event, as we were

each of the IG reports, rather than taking a holistic approach and a more comprehensive approach and looking at them together.

The CHAIRMAN. So, again, your testimony is that you were not aware of any of the scheduling problems and delays in care until April 9th?

Dr. THOMAS. I was not aware of the extent of the problem.

The CHAIRMAN. What does that mean?

Dr. THOMAS. As I said, each time an IG report was issued, we would look at it, respond to it, and create an action plan for any of the national reports.

The CHAIRMAN. Well, the interesting thing—what VA usually does is they do respond to it. It is interesting that they accept all of the recommendations—in every report that I think has ever been handed to them. It is interesting. Now I see how it works. I mean if the IG and the VA are working hand in glove backwards and forwards, they already know what they are going to agree to.

This is the first time that I can remember that VA actually is doing some of the things that they have in the past certified that they have done.

Dr. THOMAS. Sir, respectfully, I would not agree with your characterization of our relationship with the OIG.

The CHAIRMAN. I understand and I will retract that statement, but you did, I learned today, you get drafts, you respond, you make changes, it goes back to the—do you not?

Dr. THOMAS. I think it is a very important distinction to make——

The CHAIRMAN. For factual—for factual——

Dr. THOMAS [continuing]. Between the OIG report and the action plan.

The CHAIRMAN. No, no, I am not talking about your action plan; I am talking about the IG report.

But then the IG then makes 23 recommendations in this report?

Dr. THOMAS. Twenty-four.

The CHAIRMAN. Twenty-four recommendations and three have already been done. I guess what I am saying is congratulations to VA for the first time that I can recall for actually moving on the recommendations, not just certifying them and then we find out months and years later that they haven't been done. But we appreciate your being here. We do apologize for the length that you have had to be here today, but thank you very much. Ms. Kirkpatrick.

Ms. KIRKPATRICK. Thank you, Mr. Chairman, and thank you, Ranking Member. And I just want to thank our staffs. You know, we started this at noon and it has been a long day, but we need to put in this kind of effort to get it right for our veterans, so I just want to say that I really appreciate everybody's effort.

The CHAIRMAN. Thank you very much.

And again, Members, I would like to let each of you know that Sharon Helman was also invited to appear and we reached out to her attorney and we never received a response to the invitation that was issued, but she, in fact, was invited to appear, and with that, this hearing is adjourned.

[Whereupon, at 6:26 p.m., the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CHAIRMAN JEFF MILLER

I would like to welcome everyone to today's hearing titled, "Scheduling Manipulation and Veteran Deaths in Phoenix: Examination of the OIG's Final Report."

On August 26, the VA Office of Inspector General released its final report on the Phoenix VA healthcare system, which vaulted to national attention after an April 9 hearing by this committee. The OIG confirmed that inappropriate scheduling practices are a nationwide systemic problem and found that access barriers adversely affected the quality of care for veterans at the Phoenix VA medical center.

Based on the large number of VA employees who were found to have used scheduling practices contrary to Veterans Health Administration policy, the OIG has opened investigations at ninety three (93) VA medical facilities, and it found over thirty-four hundred (3,400) veterans who may have experienced delays in care from wait list manipulation at the Phoenix VA medical center alone. The OIG concluded by providing the VA with twenty-four (24) recommendations for improvement to avoid these problems from recurring. These recommendations should be implemented immediately, and this committee will work tirelessly to ensure that they are.

Mr. Griffin, I commend you and your team for your work and continued oversight on these issues in the months ahead.

With that said, I am concerned regarding the manner with which the OIG report was released, along with some of the statements contained within it. Notably, prior to the release of the report, selective information was leaked to the media, apparently by a source internal to VA, which purposely misled the public that there was no evidence at Phoenix linking delays in care with veteran deaths. As days went on, and people actually read the report, that falsehood became obvious. What the OIG actually reported, and what will be the subject of much discussion today, is this statement by the OIG: "we are unable to conclusively assert that the absence of timely quality care caused the deaths of these veterans."

What is most concerning about this statement is the fact that no one who dies while waiting for care would have "delay in care" listed as the cause of death, since a delay in care is not a medical condition. Following the release of this report, which found pervasive problems at the facility regarding delays in care and poor quality of care, committee staff was briefed by the OIG regarding its findings and how specific language was chosen throughout the drafting process.

Prior to this meeting, we requested that the OIG provide us with the draft of the report in the form it was originally provided to VA three weeks before the release of the final report.

After initially expressing reservations, the OIG provided us with the draft.

What we found was that the statement I just quoted was not in the draft report at all.

Another discrepancy we found between the draft and final reports arose with statements to the effect that one of the whistleblowers here today did not provide a list of forty (40) veterans who had died while on waiting lists at the Phoenix VA medical center. First, the OIG stated in the briefing to committee staff that VA inquired why such a statement was not in the report, and the OIG ultimately chose to include it. Further, additional information provided by the OIG to committee staff shows that, based on the numerous lists provided by all sources throughout the investigation, the OIG in fact accounted for forty-four (44) deaths on the electronic wait list alone, and an astonishing two hundred and ninety-three (293) total veteran deaths on all of the lists provided from multiple sources throughout this review.

To be clear, it was not and is not my intention to offend the Inspector General and the hard-working investigators he employs. However, I would be remiss in my duty to conduct rigorous oversight of the Department of Veterans Affairs if I did not ask these questions. I would also like to point out that no one within the department, or any other federal government employee, including the members of this committee, is above reproach.

As such, the committee will continue to ask the questions that need to be asked in order to perform our constitutional duty. It is absolutely imperative that the OIG's independence and integrity in its investigations be preserved. Full and transparent hearings like this one will help ensure that remains the case.

PREPARED STATEMENT OF MICHAEL H. MICHAUD, RANKING MEMBER

Thank you, Mr. Chairman.

Today's hearing provides the opportunity to examine the VA Inspector General's final report on the patient wait times and scheduling practices within the Phoenix VA healthcare System.

This report did not state a direct causal relationship between long patient wait times and veteran deaths. For some, that is a major concern, and accusations of undue influence by the VA on the IG report will be discussed at length today.

What the IG did find is that the cases included in this report clearly show there were serious lapses in VA's follow-up, coordination, quality, and continuity of healthcare to veterans. They also concluded that the inappropriate scheduling practices demonstrated in Phoenix are a nationwide systemic problem.

I do not need any more evidence or analysis. There is no doubt in my mind that veterans were harmed by the scheduling practices and culture at the Phoenix facility and across the nation. The bottom line is this behavior, and its detrimental effect on veterans, is simply not acceptable.

My heart goes out to the families of the veterans who did not receive the healthcare they deserved in Phoenix and around the country. Rest assured, we will understand what went wrong, fix it, and hold those responsible for these failures accountable.

As such, my questions to the VA today are straightforward—what went wrong, what are you doing to fix the problems, how will you ensure this never happens again, and how are you holding those responsible accountable?

I applaud Secretary McDonald for taking forceful action to begin to address the systemic failures demonstrated in Phoenix. We need serious, deep and broad reform—the kind of change that may be uncomfortable for some in VA, but so desperately needed by America's veterans.

I believe that such reform must be guided by a higher-level National Veterans Strategy that outlines a clear vision of what America owes its veterans, and a set of tangible outcomes that every component of American society can align and work towards. Earlier this week, I sent a letter to President Obama asking him to establish a working group to engage all relevant members of society in drafting this National Veterans Strategy.

We know from experience that VA cannot do it alone. We must develop a well-defined idea of how the entire country—government, industry, non-profits, foundations, communities and individuals—will meet its obligation to veterans.

VA needs to become a veteran-focused, customer service organization. It needs to be realigned to become an integrated organization. It should do what it does best, and partner for the rest. It needs to be the government model for honesty, integrity, and discipline.

We need to complete our investigation of the problems and provide oversight on the solutions.

I look forward to today's additional testimony about what happened in Phoenix, and how the VA is working to ensure it never happens again.

I yield back the balance of my time.

STATEMENT OF
RICHARD J. GRIFFIN
ACTING INSPECTOR GENERAL
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON
"SCHEDULING MANIPULATION AND VETERAN DEATHS IN PHOENIX: EXAMINATION OF THE OIG'S FINAL REPORT"
SEPTEMBER 17, 2014

Mr. Chairman, Ranking Member Michaud, and Members of the Committee, thank you for the opportunity to discuss the results of the Office of Inspector General's (OIG) extensive work at the Phoenix VA Health Care System (PVAHCS). Our August 26, 2014, report, *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*, expands upon information previously provided in our May 2014 interim report and includes the results of the reviews by OIG clinical staff of patient medical records. I am accompanied by John D. Daigh, Jr., M.D., Assistant Inspector General for Healthcare Inspections; Ms. Linda A. Halliday, Assistant Inspector General for Audits and Evaluations; Ms. Maureen T. Regan, Counselor to the Inspector General; and Mr. Larry Reinkemeyer, Director, OIG Kansas City Audit Operations Office.

Our recent report cannot capture the personal disappointment, frustration, and loss of faith of individual veterans and their family members with a health care system that often could not respond to their physical and mental health needs in a timely manner. Although, we did not apply the standards for determining medical negligence during our review, our findings and conclusions in no way affect the right of a veteran or, if the veteran is deceased, his or her family, from filing a complaint under the Federal Tort Claims Act with VA. Decisions regarding VA's potential liability in these matters lie with the Department, Department of Justice, and the judicial system under the Federal Tort Claims Act.

WHY WE DID THIS REVIEW

We initiated this review in response to allegations first reported through the OIG Hotline on October 24, 2013, from Dr. Samuel Foote, the now-retired PVAHCS physician who alleged gross mismanagement of VA resources, criminal misconduct by VA senior hospital leadership, systemic patient safety issues, and possible wrongful deaths at PVAHCS.

We would like to thank all the individuals including Dr. Foote and Dr. Katherine Mitchell, the Medical Director of the PVAHCS Operation Enduring Freedom/Operation Iraqi Freedom/and Operation New Dawn clinic, who brought forward their allegations about issues occurring at PVHACS and other VA medical facilities to the attention of the OIG,

the Congress, and the Nation. What these individuals demonstrated are the actions the Secretary recently said he wanted—to hear VA employees' ideas for improving the Department and for employees to bring to their managers and his attention their concerns and significant issues, so VA can make necessary changes to improve its organization. On November 26, 2013, our Office of Healthcare Inspections initiated a review of the Hotline allegations. At the request of the Chairman, Subcommittee on Oversight and Investigation, U.S. House Committee on Veterans' Affairs, on August 19, 2014, we submitted a timeline of our actions and efforts from September 2013 through April 2014. This information is presented in Exhibit A.

On April 9, 2014, the U.S. House Committee on Veterans' Affairs held a hearing during which VA officials were questioned about delays in VA medical care and preventable veteran deaths at PVHACS and across VA medical facilities. We expanded our work at the request of the Chairman, U.S. House Committee on Veterans' Affairs, and the former VA Secretary, as well as other Members of Congress. Later in the afternoon after the hearing we received an email from the Subcommittee on Oversight and Investigations that provided additional documents. One of the documents included the names of 17 veterans who died awaiting an appointment at PVAHCS and stated that potentially 40 additional veterans died waiting for an appointment. This same document stated that Subcommittee on Oversight and Investigations staff needed access to the VA's Computerized Patient Record System to "unequivocally prove" that all 40 deaths were related to delays in care. The email and document are presented in Exhibit B.

RESULTS OF OUR REVIEW

After the April 9th hearing our team of healthcare inspectors was expanded to include a multidisciplinary team composed of board-certified physicians, special agents, auditors, and additional healthcare inspectors to expand our evaluation of the allegations at PVAHCS. We examined the medical records and other information for 3,409 veteran patients, which included 293 deceased patients, and identified 28 instances of clinically significant delays in care associated with access or scheduling. Of these 28 patients, 6 were deceased. In addition, we identified 17 cases of care deficiencies that were unrelated to access or scheduling. Of these 17 patients, 14 were deceased. The qualifications of the OIG physicians who conducted these reviews are presented in the curricula vitae in Exhibit C.

The 45 cases discussed in our report reflect unacceptable delays and troubling lapses in coordination, follow-up, quality, or continuity of care. The identities of these 45 veterans have been provided to VA.

We identified several patterns of obstacles to care that resulted in a negative effect on the quality of care provided by PVAHCS. As of April 22, 2014, we identified about 1,400 veterans waiting to receive a scheduled primary care appointment who were appropriately included on the PVAHCS' official electronic wait list. However, as our work progressed, we identified over 3,500 additional veterans, many of whom were on what we determined to be unofficial wait lists, waiting to be scheduled for appointments but not on PVAHCS' official electronic wait list. These veterans were at risk of never

obtaining their requested or necessary appointments. PVAHCS senior administrative and clinical leadership were aware of unofficial wait lists and that access delays existed but did not effectively address these issues. Throughout the course of our review, we promptly provided PVAHCS interim leadership the names of all veterans we identified as being on an unofficial wait list to enable them to take the necessary actions to get these veterans the care they needed.

During our review, it became clear that the Urology Service at PVAHCS was in turmoil during the 2012 to 2014 timeframe and was unable to keep up with the demand for services. PVAHCS experienced a number of urology physician staffing changes, delays in the procurement of non-VA purchased care consults for urology, and difficulties coordinating urologic care. As a result, the OIG has an ongoing review of the PVAHCS Urology Service where we are working from a list of 3,526 patients who potentially received poor urologic care.

From interviews of 79 PVAHCS employees involved in the scheduling process, we identified scheduling practices not in compliance with VHA policy. PVAHCS executives and senior clinical staff were aware that their subordinate staff were using inappropriate scheduling practices. Further, in January 2012 and later in May 2013, the Veterans Integrated Service Network (VISN) 18 Director issued two reports that found PVAHCS did not comply with VHA's scheduling policy. Our review also determined PVAHCS still had not complied with VHA's scheduling policy as of July 7, 2014. Specifically, according to VISN 18 staff, PVAHCS had not completely trained its clerks or established electronic wait lists in the clinics. As a result of using inappropriate scheduling practices, reported wait times were unreliable, and we could not obtain reasonable assurance that all veterans seeking care received the care they needed.

The emphasis by Ms. Sharon Helman, the Director of PVAHCS, on her "Wildly Important Goal" to improve access to primary care resulted in a misleading portrayal of veterans' access to patient care. Despite her claimed improvements in access measures during fiscal year 2013, we found her accomplishments related to primary care wait times and the third-next available appointment were inaccurate or unsupported. After we published our interim report, the Acting VA Secretary removed the 14-day scheduling goal from employee performance contracts.

LACK OF ACCOUNTABILITY TO ADDRESS WAIT TIME AND ACCESS ISSUES

Since July 2005, the OIG published 20 oversight reports on VA patient wait times and access to care, yet the Veterans Health Administration (VHA) did not effectively address its access to care issues or stop the use of inappropriate scheduling procedures. When VHA concurred with our recommendations and submitted an action plan, VA medical facility directors did not take the necessary actions to comply with VHA's program directives and policy changes. In April 2010, in a memorandum to all VISN Directors, the then-Deputy Under Secretary for Health for Operations and Management called for immediate action to review scheduling practices and eliminate all inappropriate practices. In June 2010, VHA issued a directive reaffirming outpatient scheduling processes and procedures. In July 2011 an annual certification of wait times was

mandated. However, in May 2013, VHA waived the annual requirement for facility directors to certify compliance with the VHA scheduling directive, further reducing accountability over wait time data integrity and compliance with appropriate scheduling practices. Clearly, there was a failure to hold VA officials accountable for ensuring that inappropriate scheduling practices were not in use.

OIG INVESTIGATIONS AT OTHER VA MEDICAL FACILITES

The OIG Office of Investigations opened investigations at 93 sites of care in response to allegations of wait time manipulations. To date, we have completed 12 investigations. After conferring with Federal prosecutors who determined that no prosecution would be initiated on substantiated allegations involving alleged violations of law, we provided our investigative reports and related documents to VA for any administrative action it deems appropriate. Cases without proof of alleged criminal conduct would not be referred to prosecutors for prosecutive opinions. To maintain our statutory independence, and to ensure that employee due process rights are protected, the OIG cannot and does not recommend any specific administrative action against individuals. The remaining 81 investigations remain active and are being coordinated with the Department of Justice and the Federal Bureau of Investigation, as appropriate. These investigations are further confirming that wait time manipulations were prevalent throughout VHA.

IMPACT OF MEDIA COVERAGE

In February 2014, Dr. Foote alleged in a letter to the OIG Hotline that 40 veterans died waiting for an appointment, and these alleged deaths were widely reported in the media. We pursued this allegation and interviewed Dr. Foote, but he was unable to provide a list identifying 40 specific patients. He provided the U.S. House Committee on Veterans Affairs the names of 17 deceased patients, which we received from the Committee on April 9, 2014, and reviewed. However, we conducted a review of PVAHCS electronic records and were able to identify 40 veterans who died while on the EWL during the period April 2013 through April 2014. These veterans were included in the review of records for 3,409 patients, which included 293 deaths, whose names were derived from multiple sources.

Prior to issuance of the OIG's final report on August 26, 2014, over 800 news stories appeared that cited 40 veterans' deaths at PVAHCS, with much of this reporting indicating that the 40 deaths were confirmed rather than the allegations were under review. We treated these allegations as just that—allegations. We proceeded to analyze information found in medical and other relevant records to determine if we could substantiate specific allegations. As I cautioned in my May 15, 2014, testimony before the U.S. Senate Committee on Veterans' Affairs, it is one thing to be on a waiting list and it is another thing to conclude that being on a waiting list caused death. The pervasiveness of the 40 deaths in media reports—reports that reached tens of millions of Americans—was the crucial factor leading to the OIG's decision to insert the reference to 40 veterans' deaths in a revision to the original draft report.

INDEPENDENCE AND INTEGRITY OF THE OIG REPORT

On August 19, 2014, the Chairman, Subcommittee on Oversight and Investigations, sent a letter to the OIG requesting the original copy of our draft report, prior to VA's comments and adopted changes to the report. A Committee staff member made the same request on September 2, 2014, on behalf of the Chairman, U.S. House Committee on Veterans' Affairs. These concerns seem to come from our inclusion of the following sentence in the final report that was not in the first draft report we submitted to VA.

> *"While the case reviews in this report document poor quality of care, we are unable to conclusively assert that the absence of timely care caused the deaths of these veterans."*

This sentence was inserted for clarity to summarize the results of our clinical case reviews. It replaced the sentence *"The death of a veteran on a wait list does not demonstrate causality."* This change was made by the OIG strictly on our own initiative; neither the language nor the concept was suggested by anyone at VA.

On July 28, 2014, we provided VA our draft report. As a standard procedure, we included a transmittal letter that provided specific instructions to VA on the necessity to safeguard the contents of the draft report and that the contents of the draft report were subject to revision prior to issuance of the final report. We also invited VA staff to discuss any questions about the contents of the report with us. After providing VA with our draft report, we provided four additional revised drafts that had minimal changes that were made solely for purposes of accuracy and clarity that were supportable by credible factual evidence. Many of the changes were made after long, deliberate discussions among OIG senior staff who continued to review the facts and refine the language in the draft report after it was released to VA for comment until the time the final report was published. For example, VA requested we remove five cases. We did not remove the cases. We did correct one date, one set of blood pressure numbers, and consolidated our recommendations involving VHA's ethics program into one broader recommendation. In all instances, the OIG, not VA, dictated the findings and recommendations that appear in our final report.

The deliberative nature of the draft report review and comment process is a long-standing practice consistent with the principle of Inspectors General as independent and objective units of Government and long-standing practice across the Inspector General community. This process gives VA the opportunity to provide comments to ensure that the facts and findings are accurate, to obtain concurrence with recommendations, and have VA submit a plan to implement the recommendations. During this process, VA has the opportunity to raise factual issues and other concerns. To ensure each report is accurate and complete, we have an obligation to review the issues raised by VA and determine whether to make changes to the report or not. However, VA has no authority to demand that changes be made or impede the issuance of a report unless changes are made. Further, VA's response to each of our reports is included in the final report. When deemed necessary, we provide a rebuttal to information provided. This process

ensures that VA is aware of the findings and held accountable to correct any deficiencies identified in the reports through our follow-up program.

In the last 6 years, we have issued between 235 and 350 reports annually. This same draft review and comment process has been used effectively throughout OIG history to provide the VA Secretary and Members of Congress with independent, unbiased, fact-based program reviews to correct identified deficiencies and improve VA programs. These reports have served as the basis for 67 congressional oversight hearings, including 48 hearings before the U.S. House Committee on Veterans' Affairs. Noteworthy, our decision to issue an interim report was to ensure veterans receive needed health care services. This report was issued without concern that the report could potentially lead to significant changes in VA leadership as it ultimately did.

The August 19, 2014, letter from the Chairman, Subcommittee on Oversight and Investigations, requested that we include certain information regarding the standard of care in our soon-to-be published report. Among the matters he asked us to incorporate in our report was the application of VA's use of a greater than 50 percent or "more likely than not" standard for determining service-connected conditions. He believed that the same standard should be used to determine whether a veteran's death was caused by extensive delays in care related to placement on an appointment wait list. In addition, he asked us to provide him with specific information, such as whether someone in VA attempted to persuade us not to use the greater than 50 percent standard. Later that day, we received VA's comments and action plan. A copy of the August 19, 2014, letter is presented as Exhibit D.

I replied to the Chairman's letter on August 22, 2014, and again on September 4, 2014. Among the issues I addressed was that we did not undertake these reviews to make service-connection decisions or medical malpractice decisions because that is not the role of the OIG. The standard posited in the Chairman's questions is one for application in the legal system, and in fact is lower than the "unequivocally prove" standard plainly stated as the standard to apply in the Subcommittee's own analysis if given access to patient medical records, which was described in material provided by his Subcommittee staff on April 9, 2014. Details of the Chairman's request for information to be included in our final report and my two replies to him and the Chairman, U.S. House Committee on Veterans' Affairs, are presented as Exhibits E, F, and G.

CONCLUSION

The VA Secretary has acknowledged the Department is in the midst of a serious crisis and has stated that VA must work to get veterans off wait lists, address cultural and accountability issues, and use its resources to consistently deliver timely health care. The VA Secretary concurred with all 24 recommendations and submitted acceptable corrective action plans.

Our findings and conclusions provide VA a major impetus to re-examine the entire process of setting performance expectations for its leaders and managers. Along with a rigorous follow up to ensure full implementation of all corrective actions, we plan on

initiating a series of reviews based upon allegations received of appointment scheduling irregularities; barriers to access to care; and other issues that affect medical care, quality, and productivity. These reviews will provide us the opportunity to determine whether senior VA medical facility officials have effectively implemented the VA Secretary's action plan and stopped the use of inappropriate scheduling practices.

If headquarters and facility leadership are held accountable for fully implementing VA's action plans, VA can begin to regain the trust of veterans and the American public. Employee commitment and morale can be rebuilt, and most importantly, VA can move forward to provide timely access to the high quality health care veterans have earned—when and where they need it.

Mr. Chairman, this concludes our statement and we would be happy to answer any questions you or other Members of the Committee may have.

PREPARED STATEMENT OF SAMUEL H. FOOTE M.D.

Death Reports by Source

On the Secret non-reporting Electronic Waiting list	44
From the Schedule an Appointment with Primary Care Consults	39
Backlog never completed	41
Expired on AW Backlog	2
House Veterans Affairs Committee	17
On the New Enrollee Appointment Request List	28
OIG Hotline calls	21
Media reports	8
Suicides	74
Urology	4
Helpline	3
Paper wait list	1
Institutional disclosure	1
Total deaths	293

My original allegation was that up to 40 Veterans may have died while waiting for care at the Phoenix VA. The two sources that we were looking at were the Secret non-reporting Electronic Waiting List and the Schedule an Appointment with Primary Care Consults. As you can see from the above, the actual number from those two sources was 83, more than double my original estimate and nowhere close to the 293 total deaths. Primarily, it appears from the report that reviews were done on the VA's Electronic Health Records. One can imagine that it would be very difficult to determine what actually happened on patients trying to get into the system who died prior to being seen.

WRITTEN TESTIMONY OF DR. KATHERINE L. MITCHELL

for submission to

113th HOUSE COMMITTEE ON VETERANS AFFAIRS

September 2014

Written testimony submitted 9/15/14

(Oral testimony to be presented 9/17/14)

CONTENT SUMMARY

Executive Summary

The VA OIG issued the 8/26/2014 report entitled "Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System".

As per the report's executive summary, "the patient experiences described in this report revealed that access barriers adversely affected the quality of primary and specialty care at the PVAHCS". Although investigators did document local systemic barriers to quality patient care, the OIG was "unable to conclusively assert that the absence of timely quality care caused the deaths of these veterans."

After reading the case studies in the OIG report, as a clinician I was unable to reach the same conclusions as the OIG investigation team. Although I agreed with OIG's observations in many patient cases, I believe the OIG case review overlooked actual and potential causal relationships between health care delays and Veteran deaths. When evaluating cause and effect between delays and negative outcomes, I did not make any distinction between health care delays related to long appointment wait times and health care delays related to slowed diagnosis/treatment of medical conditions.

As I reviewed the OIG report, I also noted inadvertent deficits in key information that could have identified a greater number of poor quality practices. In addition, although some deaths were not preventable because of the underlying diagnosis, the missing details would have determined if those Veterans potentially suffered untimely loss of high quality days from their diminished life spans because of delays in appropriate health care.

I have no reason to believe that any information gaps or omissions in the 8/26/14 report were intentional. As I read the cases, I simply felt that there was more data needed to understand the implications and conclusions of the cases.

When reading the OIG report & conclusions, I drew upon my Phoenix VA experiences working as a former nurse, former internal medicine resident, and current physician. I considered the potential for Phoenix VA system issues that could have affected case outcome and whether or not appropriate VA services/care was offered in a timely fashion. I also deliberated whether the standards of care and treatment within the community were followed. I remained aware that there are diseases which naturally evolve into terminal illness and unavoidable death.

The omissions or gaps in information I observed are detailed in Part III section 2 of this written testimony. Part III was written to be read in conjunction with the corresponding case in the OIG report although the omissions/conclusions entries are self-explanatory. In some instances, in order to convey the implications of the omissions to those outside the health care field, I have given very simplified descriptions of disease states, treatment, or other medical processes applicable to the case.

Part III Section 1 of this written testimony summarizes significant details & omissions I believe would have changed the context and outcome of the final in the OIG report:

1. In 4 cases the OIG did not list a cause of death for the Veteran on the Electronic Wait List (EWL). Without a cause of death it does not seem possible to determine the clinical relevance of the excessive waits for initial primary care.

2. In 19 cases the OIG report did not contain information to determine if Veterans with potentially significant medical issues were informed of the walk-in process to expedite outpatient entry into and/or continued medical management within the primary care provider (PCP) clinics. Therefore it is unknown if the Veterans believed they had no other care options but to wait on the EWL for the first VA scheduled appointment. Without this information being contained in the report, it is unclear of the degree to which VA PCP appointment delays significantly contributed to a worsening of physical symptoms/quality of life. In at least two cases, those details may have revealed if the delays enabled the acute worsening of chronic illness to the point the Veterans died from the disease complications.

3. In 8 cases no information was provided to determine if the Veterans presenting with significant mental health issues and/or substance abuse issues were informed of the self-referral process to acute/chronic mental health services within the Phoenix VA. Therefore it is unknown if the Veterans believed they had no other care options but to wait on the EWL for the first VA scheduled appointment. Without such data, it is unclear of the degree to which VA mental health appointment delays significantly contributed to worsening psychological symptoms and, in at least two cases, may have been a barrier to suicide prevention.

4. In 8 cases no information was given to determine if Veterans with significant mental health, polysubstance abuse, and/or social support issues were referred by a VA provider to appropriate VA social work services and/or Adult Protective Services. Social work services can provide assistance with accessing resources to address mental health problems, homelessness, poor finances, and other psychosocial stressors. Evidence for lack of timely social work referrals would have indicated another significant opportunity missed by the VA to ensure quality care.

5. In 3 cases there was insufficient information to determine if Veterans who received delayed diagnosis/treatment of cancer or tumor had any significant residual symptoms related to health care delays in treatment. Evidence of significant residual symptoms would have indicated that delays in care were clinically relevant and would have shown the lasting impact of poor quality care.

6. Excluding cases for which there was no cause of death listed, in 3 cases there

appeared to be a causal link evident between delayed and/or improper care and Veteran death

7. Excluding cases for which there was no cause of death listed, in 2 cases there appeared to be a potential causal link suspected between delayed and/or improper care and Veteran death.

8. In 5 cases health care delays contributed to decreased quality of life and/or a potentially significantly shortened lifespan in terminally ill Veterans.

Part IV of this testimony outlines persistent PVAHCS issues that have implications for other facilities within the Department of the VA. Just as the scheduling irregularities and Electronic Wait List (EWL) issues were not unique to the Phoenix VA, other problems within PVAHCS have the potential to be mirrored in sister facilities throughout the nation.

Part V deals with brief observations on the OIG investigation.

Once considered an institution almost immune to change, the Department of Veteran Affairs is in the process of re-examining its priorities and practices in all facilities so that it can serve our Veterans well. The information included in this written testimony is intended to serve as a potential springboard for further discussion and positive change in not only the Phoenix VA Health Care System but also throughout the VHA.

III. CASE REVIEWS: : Omissions Potentially Influencing the Final Context & Conclusions of the 8/26/14 Phoenix VA OIG Report

NOTE: I must clearly state that I did not participate in the OIG's collection/review of the cases or in the construction of the official report. My involvement in the official OIG investigation was very limited. I only helped hide the NEAR list (New Enrollee Appointment Request list), participated willingly in the one interview that the OIG requested of me, and immediately turned over unprocessed enrollment forms that inadvertently were discovered.

Section 1: Brief Overview Summary*

**The information listed in Section 1 is not a comprehensive list of omissions or case implications. It provides some details not emphasized in the 8/26/14 OIG report. It highlights conclusions differing from those made by that OIG investigation. There is no distinction made between health care delays related to long appointment wait times and health care delays related to slowed diagnosis/treatment of medical conditions.*

Abbreviations used after case numbers:

"d" = deceased
"ds" = deceased because of suicide
"dus" = deceased but uncertain if from suicide attempt
blank = still living

A. Clinically Relevant Information Gaps/Omissions & Implications: Examples

1. Cause of death is not listed for the Veteran. Without a cause of death, it is not possible to determine if delay in accessing VA primary care was clinically relevant.
Cases involved: 1d, 2d, 4d, 33d

2. No information provided to determine if Veterans with potentially significant medical problem(s) were informed of the walk-in process to expedite outpatient entry into and/or continued medical management within the primary care provider (PCP) clinics. Therefore it is unknown if the Veterans believed they had no other care options but to wait on the EWL for the first VA scheduled appointment. Without this information being contained in the report, it is unclear of the degree to which VA PCP appointment delays significantly contributed to a worsening of physical symptoms/quality of life and, in at least two cases, may have caused acute worsening of medical problems to the point the Veteran died from the disease.
Cases involved: 1d, 2d, 4d, 5dus, 6, 7, 8, 9, 10, 11, 15, 17, 19, 20, 22, 23, 24, 25, 26

3. No information provided to determine if the Veterans presenting with significant mental health issues and/or substance abuse issues were informed of the self-referral process to acute/chronic mental health services within the Phoenix VA. Therefore it is unknown if the Veterans believed they had no other care options but to wait on the EWL for the first VA scheduled appointment. Without such data, it is unclear of the degree to which VA mental health appointment delays significantly contributed to a worsening of psychological symptoms and, in at least two cases, may have been a barrier to suicide prevention.

Cases involved: Cases 16, 19, 20, 24, 26, 27ds, 28, 42ds

4. No information given to determine if Veterans with significant mental health, polysubstance abuse, and/or social support issues were referred by a VA provider to appropriate VA social work services and/or Adult Protective Services. Social work services can provide assistance with accessing resources to address mental health problems, homelessness, poor finances, and other psychosocial stressors. Evidence for lack of timely social work referrals would have indicated another significant opportunity missed by the VA to ensure quality care.

Cases involved: 1d, 2d, 9, 19, 20, 26, 38d, 41d

5. Insufficient information to determine if Veterans who received delayed diagnosis/treatment of cancer or tumor had any significant residual symptoms related to health care delays in treatment. Evidence of significant residual symptoms would have indicated that delays in care were clinically relevant and would have shown the lasting impact of poor quality care.

Cases involved: 10, 12, 14

B. Causal Relationship Evident Between Delayed and/or Improper Care & Veteran Death (excluding Veterans for which cause of death was not listed): Cases 29d, 36ds, 39ds, 40ds

1. Case 29d

This patient had a severe cardiomyopathy which is a disease of the heart muscle that progressively impairs the heart's ability to pump blood and to maintain a normal heart rhythm. A patient with severe cardiomyopathy is at high risk for having his heart suddenly stop beating without any warning as the results of a life-threatening heart rhythm known as ventricular fibrillation ("v-fib").

The treatment to avoid sudden death from v-fib/cardiomyopathy is permanently inserting a medical device known as an ICD "implantable cardiac defibrillator". Immediate defibrillation (giving the heart an electrical shock) has the best chance to restart the heart and prevent death or complications from prolonged v-fib such as brain damage or permanent heart muscle damage.

Per community medical standards, an ICD should be implanted quickly in patients diagnosed with severe cardiomyopathy. Unfortunately, this Veteran waited at least 4+ months after the

original cardiac consultation without having ICD placement scheduled. (Exact wait time could not be determined because OIG did not give dates in its report.)

Delayed scheduling of an ICD implant allowed the Veteran to have an episode of prolonged v-fib which resulted in severe damage to the brain/body from which the Veteran could not recover. Life support was withdrawn 3 days after he collapsed and was found to be in v-fib.

Although OIG concluded "ICD placement might have forestalled that death", the investigators didn't draw any direct connection between delayed access to specialty care procedure and the Veteran's death.

Conclusion: The Veteran died from complications of prolonged v-fib because he didn't have access to appropriate/timely specialty care for ICD placement that would have immediately treated v-fib.

2. Case 36ds

This Veteran with multiple medical problems had both depression and a history of chronic pain that was not well controlled. When his pain significantly worsened, he made statements to various VA health care providers indicating his pain was severe that he was feeling like "it might make him suicidal" and that he "could cry [because of pain]". However, the Veteran denied having any overt suicidal thoughts. The OIG did not give any indication that the PCP provider responded to this Veteran's message(s) regarding the worsening pain control.

When the Veteran did present in person to the walk-in PCP clinic to get treatment for the pain, the Veteran apparently was only referred to mental health to address the side effect of pain (depression) and did not get medical interventions to relieve the pain. The same day, the patient called the National Suicide Prevention Hotline to complain of "severe and chronic pain unresponsive to treatment" and complained that his PCP was not responding to his requests for contact. A consult was placed to the suicide prevention coordinator but the consult was closed, presumably because the Veteran indicated the issue was related only to severe/unrelenting pain and denied having suicidal thoughts. Within one week the Veteran committed suicide without ever having any medical intervention to control his unrelenting, severe pain.

As per the OIG, this patient should have been identified as having a high risk for suicide because of underlying depression. However, even if this had been done, it is clear that the impetus for the suicidal thoughts was unremitting, severe pain which was never addressed by the PCP.

The OIG did not draw a connection between the lack of PCP response/treatment of acutely worsening unrelenting pain and the Veteran's subsequent suicide.

Conclusion: The Veteran did not receive appropriate/timely care for his unrelenting, severe pain that served as the impetus for his suicidal thoughts and ultimate suicide.

3. Case 39ds
This homeless Veteran had a history of PTSD, 3 suicide attempts requiring hospitalization in the prior 2 years, and schizoaffective disorder which is a serious psychiatric diagnosis predisposing him to irrational thoughts, paranoia, and hallucinations.

At the time of presentation to the ER, this patient was having intense emotional stressors as evidenced by the comment that he " hates life and it is so stressful that he doesn't want to be in it". He also reportedly felt suicidal because he could not afford to stay at his motel. While inability to pay for a motel is normally not a reason for suicidal thoughts, this Veteran was predisposed to irrational thoughts based on his psychiatric diagnosis and could have easily felt overwhelmed at the thought of living on the streets again.

Despite his psychiatric history and intense current social stressors, the Veteran inexplicably was rated as having a low risk for suicide. Since the Veteran was not appropriately admitted to an inpatient unit where he his risk of completing suicide would have been almost zero, the Veteran found himself again in an unstable environment. He committed suicide the next day

Recognizing the Veteran's risk factors for suicide and acute psychiatric instability, the OIG wrote psychiatric admission "...would have been a more appropriate management plan" for this patient with a history of "multiple suicide attempts, psychosis, homelessness". However the OIG failed to draw a connection between inappropriate discharge from the ER and this unstable Veteran's suicide the next day.

Conclusion: Lack of appropriate psychiatric admission for a patient with multiple risk factors for suicide enabled a death from suicide within 24 hours from point of last VA mental health/ER contact.

4. Case 40ds (almost certainly a suicide based on context)
This Veteran had a history of suicidal thoughts, 7 former psychiatric hospitalizations for mental health instability, and a history of hurting himself. He had been admitted to the Phoenix VA inpatient psychiatry unit because of suicidal thoughts, thoughts of harming his brother, and self-reported difficulty controlling his rage.

Although the Veteran denied suicidal/homicidal thoughts on the day of discharge, his behavior/demeanor on the inpatient ward and at the family conference indicated the Veteran was not yet stabilized psychiatrically on medication.

The Veteran was discharged home presumably by his insistence. Neither the family nor the VA inpatient psychiatry staff tried to block this discharge by requesting the Court grant permission to keep this patient involuntarily until his meds could be stabilized.

Two days later, the Veteran was found dead from a "possible overdose on medication" which, in this context, is consistent with suicide. Even if this was an accidental overdose, the Veteran's psychiatric presentation indicated very poor impulse control that often predisposes an individual to make irrational decisions such as overuse of medication.

The OIG wrote it "would have been prudent" to continue the inpatient hospitalization (either voluntary or involuntary) for this Veteran. Failure to prudently continue inpatient psychiatric care resulted in discharge of a Veteran to an unmonitored outpatient setting wherein the Veteran died from a suspected overdose 2 days later. If the Veteran would have remained on the inpatient psychiatric unit, his risk of accidental/intentional death would have been almost nonexistent.

The OIG did not draw a connection between lack of "prudent" continued psychiatric inpatient care and the death of this unstable Veteran from suicide two days later.

Conclusion: Premature discharge from a psychiatric ward for a patient with multiple risk factors for suicide enabled a death from suicide within 48 hours from point of last VA mental health contact.

C. Causal Link Suspected between Delayed and/or Improper Care & Veteran Death (excluding Veterans for which cause of death was not listed): Cases 30d, 42d
1. Case 30d

Four days after starting a strong pain medication to control new "torso pain", this Veteran died from complications related to having a perforation (hole) in his bowels that leaked bacteria into his blood stream and caused infection throughout the body.

Unfortunately, because of poor VA medical record documentation, it cannot be conclusively established whether or not the new "torso" pain was related to the pending bowel perforation. However, as per the OIG report, a new location of severe pain should have warranted prompt evaluation which unfortunately was not done. It is clear the Veteran had improper triage assessment of his new pain.

In this clinical context, there should be a high clinical suspicion that the torso pain was actually early signs of chest/abdominal pain associated with pending perforated bowel. Usually patients will experience new/worsening pain for a few days prior to the actual perforation.

When the Veteran did present to the ER and was discovered to have a perforated bowel, the surgical intervention/operation required to treat this Veteran was significantly delayed for reasons not listed in the OIG report. Normally, large perforations and/or delayed surgical repair of the perforation are associated with worse outcomes including overwhelming infection and death.

The OIG concluded that "earlier diagnosis and treatment might have altered the outcome in this case." However, assuming the new torso pain was related to the pending bowel perforation, more thorough triage & prompt assessment /treatment definitely would have prevented the course of clinical deterioration that led to this Veteran's death. Earlier surgical intervention would have had a greater likelihood of altering the outcome in the Veteran's favor because early surgical intervention is one of the keys to preventing complications leading to death.

Conclusion: A Veteran did not have timely access to appropriate medical care that would have enabled the earlier diagnosis/surgical treatment needed to vastly improve the outcome in this case and reduced the risk of untimely death.

2. Case 42ds

After completing a month long inpatient substance abuse treatment program, this Veteran apparently was discharged without any referral for ongoing mental health care to support his early sobriety/psychiatric issues common to early recovery. Although medical care for chronic non-psychiatric health care issues was scheduled for 3 months after discharge, the Veteran committed suicide 2 weeks before that appointment.

The OIG wrote "this patient should have had follow-up established with a PCP or mental health provider sooner than the 12 weeks that were planned [for the PCP appointment]." The OIG did not list any dates for mental health care appointment. This would indicate that there were no mental health appointments scheduled upon discharge from the PVAHCS Substance Abuse Residential Rehabilitation Treatment Program.

If the VA failed to establish an appropriate mental health follow-up plan upon discharge, then the VA missed the opportunity to support/stabilize the Veteran during the early recovery phase and went against community mental health treatment standards. Although unknown stressors likely occurred between the discharge date and the Veteran's suicide 10 weeks later, without a mental health follow-up plan, the Veteran would have been much less likely to be able to handle the stressors and thus would have had a higher risk of suicide.

Conclusion: If there was no mental health discharge follow-up plan, then the VA failed to meet the community standards for mental health treatment. In the absence of an appropriate discharge plan, there is a relationship between inadequate mental health post-discharge care and his subsequent mental health deterioration resulting in suicide 10 weeks after last VA mental health care contact.

D. Care Delays Contributing to Decreased Quality of Life and/or Significantly Shortened Lifespan in Terminally Ill Veterans: Cases 3d, 31d, 32d, 34d, 37d

1. Case 3d

During the 4+ months this Veteran was awaiting a PCP clinic assignment, this male smoker was having persistent flu-like symptoms for which he was unable to schedule a Phoenix VA PCP appointment for evaluation. The Veteran finally went to a non-VA medical facility where he was treated for pneumonia and found to have a CT scan changes consistent with a large left lung mass/abnormal lymph nodes that were consistent with spreading lung cancer. Two weeks later he walked into the Phoenix VA PCP clinic to be seen. It would take one month to have the follow-up lung CT scan completed and another one month before further diagnostic studies were completed confirming the diagnosis of widely spread lung cancer. Because the cancer was very advanced, the Veteran was referred to hospice care services. Per the OIG, there was never any confirmation the medical chart that the Veteran actually received hospice care services or where the patient died.

The OIG was correct when it stated that even though earlier diagnosis would not have prevented the death from cancer, this Veteran was denied the timely opportunity for palliative care services that could have ensured better quality of life in his final days/weeks/months.

Conclusion: Per the OIG report, lack of PCP appointment on VA registration "does not mean that the patient's lung cancer would have been detected sooner. However, an earlier PCP appointment for a symptomatic male smoker would have conferred a higher chance of cancer detection than the zero probability of detection that existed without a PCP appointment. It only took one visit to a non-VA medical facility to diagnose suspected cancer.

2. Case 31d

This Veteran died of metastatic prostate cancer that was not treated during the 7 month period that the VA failed to address an abnormal lab test indicating the return of prostate cancer. By the time the lab test was repeated, Vet had persistent back pain consistent with significant spread of prostate cancer to the bones in his lower spine.

Although treatment for prostate cancer was initiated, this Veteran's cancer had progressed too far. The Veteran eventually died in hospice after an unknown amount of time receiving prostate cancer treatment.

Earlier detection of the prostate cancer would have been possible if the Veteran had access to timely specialty care or a subsequent provider had recognized the significance of the earlier abnormality in the lab test . Although metastatic prostate cancer may not be cured, early treatment can slow down its progression by months/years and promote quality of life by slowing the down bony destruction from cancer.

Conclusion: Because of unavailability of scheduled urology appointments and subsequent missed abnormal prostate lab finding, this Veteran was denied timely access to specialty care/treatment that likely would have forestalled the patient's death by months/possibly 1+ year and certainly would have improved quality of life.

3. Case 32d

This Veteran was initially admitted to the VA hospital to work up suspicious liver abnormalities that, in retrospect, were indications of advanced cancer. The Veteran was discharged home with the expectation of an outpatient liver biopsy presumably to confirm the diagnosis of suspected cancer. The contact information was not accurate on discharge so the staff couldn't reach the patient to schedule the outpatient follow-up. Ultimately, the biopsy was not done because the patient's symptoms/presentation were consistent with widespread cancer of some type and the risk of doing a biopsy was too great in this very ill Veteran.

The OIG report is unclear but implies the Veteran presented at least once to the ER after the initial VA hospitalization and at least once to the primary care clinic. During one of those visits (site unknown) he was not admitted even though the Veteran had intractable (severe/unrelenting) abdominal pain and probable metastatic (widespread cancer) disease. The second VA visit a week later (location of visit not specified) resulted in an admission to the hospital and death in a hospice unit approximately 4 days later.

It is unclear why this Veteran with "intractable abdominal pain and probable metastatic" cancer was not admitted to the hospital during the initial VA visit (ER versus outpatient clinic) so his severe abdominal pain could be treated. There are no details to determine if the Veteran refused admission or if the admission was never offered.

His clinical presentation on the initial hospitalization must have been consistent with advanced cancer because that was the clinical presentation 2 weeks later on the second admission to the hospital. Timelier follow-up with a cancer specialist could have facilitated discussion on the prognosis as well as the benefit of hospice care for his remaining 2-3 weeks of life. As the events transpired, the Veteran was only on hospice for a maximum of 3 days before death.

Conclusion: Although earlier diagnosis/biopsy would not have prevented the death from wide spread cancer, this very ill Veteran was denied the timely opportunity for palliative care services that could have ensured better quality of life in his final weeks before death.

4. Case 34d

While hospitalized for a new stroke work-up, this middle-aged Veteran who had risk factors for lung cancer was found to have an abnormal "large density" (a big abnormal area of tissue) on his chest x-ray. No CT scan or other study was done to determine what might be the cause of the mass. The Veteran was discharged home and readmitted 6 weeks later because of

shortness of breath. After being diagnosed with lung cancer during the second hospitalization, the Veteran was discharged to hospice and died a few days later.

Normally, a middle aged male smoker with a new large lung abnormality is presumed to have a cancer diagnosis until proven otherwise. In a non-VA facility, a physician would have initiated a work-up to include at least an initial chest CT scan prior to discharge. Significant chest CT scan abnormalities would have indicated the need for rapid referral to a specialist for evaluation. If advanced, non-curable cancer was present, the palliative care/hospice options would have been appropriately discussed with the patient.

The purpose of palliative care services for a patient with grossly advanced cancer is to manage symptoms and address the psychosocial and spiritual issues prominent in the final stages of life so that quality of life is preserved until death.

Conclusion: This Veteran was denied timely access to diagnostic studies that would have indicated advanced/incurable lung cancer. Although his life span may not have been prolonged in the setting of advanced lung cancer, earlier evaluation would have allowed more timely hospice services to preserve quality of life during the last 2 months before death.

5. Case 37d

Ten months after a questionable biopsy of a lung mass suspicious for cancer, a Veteran died of metastatic melanoma (type of cancer) that can spread rapidly throughout the body. Because there was no definitive biopsy/autopsy details to determine if the lung mass was melanoma or not, the OIG wrote "the death may not have been related to the lung mass".

Normally, when a suspicious mass is noted on chest x-ray & lung CT scan and then 10 months later the patient is found to have metastatic cancer in the brain, the clinical suspicion is high that the original lung mass was cancer.

Although the OIG acknowledged the management of the mass was inadequate, it wasn't clear if the OIG followed due diligence to determine how likely the lung mass was cancer. In this Veteran's case, he had brain surgery in a non-VA hospital 11 months after the lung biopsy. Per community standards of care prior for surgery, the Veteran would have had at least a chest x-ray and possibly a chest CT scan at the non-VA hospital prior to neurosurgery. If there was a significant increase in lung mass size between the original VA x-rays/CT scan and those non-VA x-rays/CT scan 11 months later, then there is an extremely high probability the lung mass was melanoma also. The Veteran was also followed by PVAHCS palliative care services for 6 months prior to his death. It is unclear if there would have been a chest x-ray during that time to which comparison could be made to the original chest x-ray done prior to lung biopsy.

Because any melanoma can be aggressive, if the lung mass was truly melanoma, then the Veteran already had a terminal illness at the time of the lung biopsy. However, lack of follow-up care in the setting of this terminal illness would have meant the patient was denied the

opportunity for palliative care treatment interventions that may have slowed the cancer spread to allow more days in his life. If the timeframe of disease progression could not have been altered, palliative care/hospice services would have at least promoted higher quality of life in the days/weeks/months prior to his death.

Conclusion: This Veteran was denied timely access to follow-up medical care that may have detected a possible aggressive cancer. Assuming the lung mass was incurable melanoma, the lack of follow-up care denied him the ability to receive medical interventions that would have contributed to greatly increased quality of life in his remaining lifespan.

E. Special circumstance: Case 35ds

1. Case #35

PLEASE NOTE: The information presented in the paragraph below is given based upon limited knowledge of a Phoenix VA patient outcome that matches the details provided by the OIG for case #35. If this is the same patient then following information was a glaring omission in the OIG report. Even if it is not the same patient, this case is important to highlight how a single barrier to health care access can have cascading consequences.

A Veteran with underlying depression called his family to ask for help managing his worsening mental health symptoms. This Veteran initially presented with his family members to the walk-in mental health clinic for assessment and care. The Veteran had never been enrolled at the Phoenix VA. Because the Veteran denied having an acute crisis when he presented to the front desk, he was diverted to the Enrollment & Eligibility Clinic for "hours" . He did not have a formal nursing triage assessment prior to this diversion. The Veteran returned too late in the day to be seen by mental health staff in the clinic. He then was diverted to the ER, again waited a lengthy time to be seen, and eventually had a mental health assessment by the psychiatric nurse. By the time he was seen by the ER staff, the Veteran was tired, wanted to go home/declined admission, and denied any suicidal or homicidal thoughts. He agreed to return the next day to the same mental health clinic he had attempted to see earlier. The Veteran committed suicide the next day.

At that time Veterans presenting to the Jade-Opal walk-in mental health clinic would be diverted to Eligibility and Enrollment Clinic if they had never been enrolled in the PVAHCS before and assuming they were not deemed to be having an acute crisis like suicidal or homicidal thoughts. Those Veterans would not undergo formal nursing triage assessment prior to being sent to the Eligibility and Enrollment Clinic. Such diversion is against community standards for acute mental health treatment.

Conclusion: Although it is unknown if the suicide could have ultimately been prevented, the registration process in the mental health clinic served as an impediment to good patient care for this Veteran with self-reported worsening depression.

III. CASE REVIEWS: : Omissions Potentially Influencing the Final Context & Conclusions of the 8/26/14 Phoenix VA OIG Report

Section 2: Specific Case Reviews*

**This section was designed to be read in conjunction with the 8/26/14 OIG Report. This section was designed to expand upon the information in that report, not repeat all the OIG case details.*

The omissions or gaps in information I observed in the OIG cases are described below. In order to convey the importance of the omissions to those outside the health care field, I have given very simplified descriptions of disease states, treatment, or other Phoenix VA processes applicable to the case details found in the OIG report.

All of the case events would have impacted the Veterans quality of life but the length and degree of impact could not be established easily in most of the cases.

Abbreviations used after case numbers:

"d" = deceased
"ds" = deceased because of suicide
"dus" = deceased but unclear if from suicide attempt
blank = still living

Case #1d

This homeless Veteran presented with poorly controlled diabetes to the Phoenix VA ER. He was discharged on oral diabetic medication to await follow-up treatment with a primary care provider (PCP). Over the next 2 months during which he did not receive a PCP appointment, the Veteran had 2 non-VA hospitalizations before he died of reasons that are not specified in the OIG report.

Uncontrolled diabetes can present with a variety of symptoms including excessive thirst, weight loss, generalized weakness/fatigue, and difficulty concentrating. Severe blood sugar abnormalities can lead to coma and death.

Adequate diabetes control is much more likely to be achieved if the patient has a stable home environment, scheduled/healthy meals, close monitoring of blood sugars, good adherence to prescribed medication regime, appropriate daily exercise, diabetes education, and routine visits arranged with health care providers. Therefore diabetes management is considered challenging in a patient who is homeless and has limited access to the social/financial support system that would normally enhance diabetes control.

The Phoenix VA Health Care System (PVAHCS) has a large social work service department to address the various needs of Veterans.

The PVAHCS manages a weekday resource center for Veterans who are/are at risk for homelessness. This center can assist Veterans with access to health care (medical, mental health, & substance abuse), transitional housing, employment resources, and coordination of community services.

Omission:

1. There is no notation if this Veteran was referred to Phoenix VA homeless services and/or other social work services that could have assisted with housing, medical care, or financial/social issues. Until approximately April 2014, the ER did not have easy access to social work services because of understaffing.

2. It is unclear if the Veteran was advised to present as a walk-in to the Primary Care Clinic to arrange for follow-up diabetes management in the event a timely primary care provider (PCP)appointment was not available. Although the process can be cumbersome depending on the PCP clinic, the Veteran could have presented on a regular business day to initiate care for his medical problems.

3. It is unclear for how many days the Veteran was prescribed metformin to control his blood sugars while he awaited evaluation from a primary care provider. At the time this Veteran was seen in the ER he would have likely only received 3-10 days of diabetes medications. Without the medication, the Veteran would not have been successful controlling his blood sugar.

4. The reasons for the non-VA ER visits are not listed. Therefore it cannot be determined if those non-VA ER visits were related to uncontrolled diabetes, medication reaction, or other issues. If the non-VA ER visits were related diabetes/diabetes medication, then timelier access to the PCP appointment could have prevented those non-VA ER visits.

5. There is no admitting diagnosis listed for either of the two non-VA hospitalizations so it cannot be determined if they were related to diabetes or other worsening chronic illness. If the admissions were related to uncontrolled diabetes, then the delay in obtaining a VA PCP appointment for diabetes management could be viewed as having a significant negative impact on the Veteran's health status and quality of life.

6. There is no notation as to whether the non-VA hospitals tried to transfer the Veteran to the VA for care. Such a transfer request is commonly made for Veterans in the community hospitals. However, the VA doesn't always have inpatient beds available to accept the transfer.

7. There is no official cause of death listed. It is unknown if the death was related to a complication of diabetes or another issues unreported or insufficiently addressed during any ER visit or hospitalization.

Conclusion: Uncontrolled diabetes would have negatively affected this Veteran's quality of life. However, without a cause of death, it is not possible to determine the relationship between the Veteran's death and his lack of timely access to a VA PCP appointment for health care.

Case #2d

This Veteran with multiple medical problems including liver disease, diabetes, heart problems, and a history of homelessness was awaiting assignment of a primary care appointment after he presented to the Phoenix VA ER with weakness and diarrhea. The Veteran was discharge from the ER. Within 4 days, he had declined to the point that he required admission to a non-VA hospital. Approximately 11 weeks later he had another non-VA hospital admission after presenting with signs of severe liver failure. Neither date of death nor cause of death is listed in the OIG report. It is stated that a PCP appointment became available three months after the patient died.

Multiple co-morbidities (having 2 or more co-existing medical problems) greatly complicates the health care management of patients because any one disease process can make the individual more likely to suffer complications or worsening symptoms from any of the other medical problems.

However, multiple medical problems present in one individual does not mean that individual is terminally ill or actively dying. Many individuals have multiple medical diagnoses but, with proper management, are not expected to have shortened life spans.

Hepatic encephalopathy (confusion caused by chemical changes related to a build-up of ammonia in the body) indicates advanced cirrhosis (liver disease) but does not indicate pending death. The symptoms of hepatic encephalopathy often are controlled using a certain medication on a regular basis. While liver disease will advance, such progression can be relatively slow unless there is another contributing factor damaging the liver such as regular alcohol intake.

Omission:

1. Insufficient information listed to determine if Veteran's underlying chronic medical problems were unstable at baseline or if the delay in care resulted in acute worsening of medical problems to the point the Veteran died from the disease. It is unclear if this Veteran had multiple medical diseases in such an advanced state that death could be imminent at any time.

Nothing in the written presentation stated the Veteran had end stage cirrhosis (risk of imminent liver failure), decompensated congestive heart failure (worsening ability of the heart to pump blood properly at rest or with minimal activity), or advanced emphysema (a type of lung disease associated with air trapping in the lungs so the person becomes very short of breath with at rest or with minimal activity).

As mentioned previously, advanced disease states cause a high risk of having suddenly shortened lifespans. Chronic, compensated disease states would be associated with a longer life span.

2. There are not enough details about the initial ER presentation to determine if the ER discharge was appropriate or not. Depending upon the seriousness of his symptoms, this Veteran who presented with weakness and diarrhea could have been at risk for worsening cardiac function, worsening kidney function, electrolyte abnormalities, worsening liver function, and/or hypotension (low blood pressure).

3. There is no notation whether or not this Veteran was referred by the ER to Phoenix VA homeless services/social work services that could have assisted with housing, medical care, or other financial/social issues.

4. The origin of the second "Schedule an Appointment" consult which was placed two days after the first consult is unknown. Generally, a second consult means the Veteran presented again to some VA employee to report medical complaints and/or to request an appointment.

It would be important to note whether or not the Veteran presented for care again. If he did, it should be examined whether his complaints were triaged appropriately. These details are crucial because two days after the patient presumably had some point of VA contact, the patient became ill enough to merit hospitalization at a non-VA facility.

5. There is no indication as to whether or not the non-VA hospital tried to transfer the Veteran to the VA for care or arrange post-hospital care/prescriptions. Such a transfer request is usually standard for our Veterans in the community hospitals. Unfortunately, the VA doesn't always have inpatient beds available to accept the transfer.

6. The patient was admitted to another non-VA facility 11 weeks later for treatment of hepatic encephalopathy. Hepatic encephalopathy doesn't cause death but can lead to other complications causing death. It is not stated if the Veteran died during that hospitalization. Assuming the Veteran didn't die while hospitalized, it is unknown if that facility tried to contact the VA for transfer/discharge planning.

7. Neither the cause of death nor the date of death is listed.

8. If the Veteran was in a habit of being compliant with medical care, then the VA delay in providing a PCP appointment for medical management certainly would have had a significant negative impact on this Veteran's quality of life and total life expectancy.

Conclusion: Without a cause of death, it is difficult to draw a conclusion about whether there was a causal relationship between the Veteran's death and his lack of timely access to a VA PCP appointment for management of his chronic medical conditions.

Case #3d
During the 4+ this Veteran was awaiting a PCP clinic assignment, this male smoker was having persistent flu-like symptoms for which he was unable to schedule a Phoenix VA PCP appointment for evaluation. The Veteran finally went to a non-VA medical facility where he was treated for pneumonia and found to have a CT scan changes consistent with a large left lung mass/abnormal lymph nodes that were consistent with spreading lung cancer. Two weeks later he walked into the Phoenix VA PCP clinic to be seen. It would take one month to have the follow-up lung CT scan completed and another one month before further diagnostic studies were completed confirming the diagnosis of widely spread lung cancer. Because the cancer was very advanced, the Veteran was referred to hospice care services. Per the OIG, there was never any confirmation the medical chart that the Veteran actually received hospice care services or where the patient died.

The various types of lung cancer have specific patterns of growth and spread. Non-small cell lung cancer is described in terms of size, how far it has spread from the original tumor, whether or not lymph nodes are involved, and if there are sites of lung cancer cells in other parts of the body.

Non-small cell lung cancer can invade the tissue immediately around the tumor and/or spread via the lymph system. When spreading through the lymph system, the cancer can cause the lymph nodes to have an unusually prominent or large appearance. The more lymph node abnormalities present, the higher the risk that the cancer may have/will soon spread to other parts of the body.

Early diagnosis and treatment confer the best chance of either cancer cure or partial remission. Delays in diagnosis allow the cancer a chance to advance to the point where cure is virtually impossible. However, even when cure/remission is not possible, there are medical interventions that can prolong life while still preserving quality of life in those who are "terminally ill" (having a disease that will eventually shorten life span/cause death) but who are not yet actively dying.

Omission:
1. At the point of registration, it is unclear if the Veteran and/or family were advised to have the Veteran present as a walk-in to a PCP Clinic for evaluation of persistent flu-like symptoms. He could have presented on the next regular business day.

2. "Localized spread of malignancy" was noted on a CT (CAT) scan report describing a large left lung mass and enlarged lymph nodes. The OIG report doesn't state if the overall appearance of the lung mass & lymph node abnormalities reported on the initial non-VA CT scan report differed from those seen on the VA CT scan completed roughly 6 weeks later. A significant difference in the location of the tumor/size of the lymph nodes those two CT scans would have indicated a rapid cancer spread during the time frame between diagnosed by a private physician and being evaluated by a VA health care provider. A rapid change would indicated

that any delay in obtaining follow-up evaluation/care likely would have negatively impacted either the quality or quantity of life for this Veteran even though the cancer was likely incurable.

3. There is no notation as to whether the CT scan in this case was ordered as "stat", "ASAP", or "routine" for purposes of scheduling. Chest CT scans can be done in 15 minutes or less. Unfortunately, the PVAHCS Radiology department frequently had a backlog of CT scan orders. Unless the CT is ordered as "stat" it could take 2 weeks - 8 weeks to get a CT scan done when it is ordered "ASAP" or "routine".

4. In view of the initial CT scan presenting classically for lung cancer with metastasis (distant spread), it is not clear why there was a delay in doing a definitive diagnostic test for the cancer or evaluation of the metastasis of that cancer via PET scan.

5. The purposes of palliative care services for a patient with grossly advanced cancer is to manage symptoms and address the psychosocial and spiritual issues prominent in the final stages of life so that quality of life is preserved until death. It would have been a medical disservice not to have provided an avenue for hospice services. It is not clear what prevented VA social services from doing outreach to this family/Veteran to determine if appropriate hospice care was in place.

Conclusion: Per the OIG, there is no way to determine if the patient's cancer would have been detected by a more timely PCP appointment. However, an earlier PCP appointment for a symptomatic male smoker would have conferred a higher chance of detection than the zero probability of detection that existed without a PCP appointment. (It only took one visit to a non-VA medical facility to diagnose suspected cancer.)

The OIG was correct when it stated that even though earlier diagnosis would not have prevented the death from cancer, this Veteran was denied the timely opportunity for palliative care services that could have ensured better quality of life in his final days/weeks/months.

Case #4d

A "deep vein thrombosis" (DVT) is a blood clot in a very large, deep vein. DVT in the legs has the potential to be life-threatening if the clot moves via the blood stream to the lungs causing a "pulmonary embolus" (clot in the lung blood vessels).

Anticoagulant medication include several types of meds that can "thin the blood" and prevent the formation and/or enlargement of abnormal blood clots. If the clot stops growing, then the body's natural repair process can help stabilize and/or dissolve the clot before it has a chance to spread to the lungs and cause a clot in lung blood vessels.

Although DVT can occur spontaneously, it is important to rule out potential causes of/risk factors for DVT such as certain sedentary physical activities, some medications, hidden cancer, or blood system abnormalities.

The length of treatment with anticoagulation medication depends upon the likelihood that the clot will reform sometime after the medication is stopped. Depending on the reason for the DVT formation, the length of treatment can be as little as 3-6 months or can be lifelong.

Anticoagulant medication has a high risk for side effects and must be closely monitored by trained providers in order to avoid life-threatening complications like severe bleeding/anemia. Although anticoagulant medications do not cause bleeding, those meds can cause any minor bleeding to become quite serious.

Individuals who chronically abuse alcohol are at higher risk for bleeding within the body because of the effects alcohol can have on the liver as well as the direct and the lining of the esophagus, stomach, and intestines.

Omission:

1. It is not clear if the Veteran was followed by any health care provider while he was on anticoagulation medication after hospitalization or for what length of time that medication was prescribed on discharge. In general, the length of time for such anticoagulation would have been at least 3-6 months, perhaps longer depending on the situation. However, new hospital prescriptions generally are dispensed for approximately one month.

In general, the Phoenix VA Anticoagulation Clinic closely monitors patients newly started on anticoagulants. However, the clinic will only monitor patients who have assigned primary care providers (PCP) because of the need to interact with that PCP.

2. It is unknown if a cause of the DVT was identified during the hospitalization or if such a medical work-up was delayed awaiting a primary care visit.

3. It is never stated whether the anemia (low red blood count) noted on the second ED visit was long-standing or if the anemia was newly developed since the Veteran's hospital discharge two weeks earlier. New onset anemia or sudden worsening of chronic anemia needs prompt attention. It is not stated if the Veteran or his family was made aware of the clinical significance of the anemia and the need to expedite care with a medical provider.

4. It is unclear if the Veteran was advised to present as a walk-in to the Primary Care Clinic for evaluation of his medications when he was discharged from the hospital and/or the ER.

5. The cause of death was not listed for this patient. The actual cause of death is needed to determine to what degree his death may have been forestalled by a timely care in the setting of anemia of uncertain origin, DVT, and high risk medication use in a Veteran with a presumably active alcohol use.

Conclusion: Without addition information including a cause of death, it is not possible to determine the degree to which delays in VA care were related to the Veteran's death.

Case #5dus
Chronic pancreatitis (inflammation of the pancreas) can lead to recurrent severe abdominal pain that often requires narcotics to control.

The control of such pain is more complicated when the patient has an active polysubstance abuse disorder or a history of substance abuse disorder. Active polysubstance abuse may predispose the individual to over-reliance on the narcotics to manage issues other than pain control. Former or current polysubstance abuse can place the patient at risk for needing higher doses of narcotics to control pain because he/she is habituated to the lower doses of narcotics. Higher doses of narcotics confer a higher risk for narcotic side effects including breathing difficulties and death.

Chronic uncontrolled pain is a risk factor for anxiety, stress, depression, and suicidal thoughts/actions.

Omission:
1. It is unclear to what degree the ER physician worked up the abdominal pain to determine if there was a reason for the sudden worsening of chronic pancreatitis pain.
It is not stated if the Veteran was actually having worsening of his chronic pain for unknown reasons or if the Veteran simply ran out of his usual pain meds to control his usual pain. Sudden onset of worsening pain requires evaluation and sometimes hospitalization to control the symptoms of worsening pancreatitis.

2. In the event a primary care appointment could not be assigned prior to the Vet running out of ER-issued pain meds, it is unclear if the Veteran was advised to present as a walk-in to the Primary Care Clinic for management of his medical issues including chronic pancreatitis and pain.

3. The cause of death on the death certificate was "multiple prescription medication intoxication". It is not stated whether or not that overdose was determined to be accidental or the result of a deliberate suicide act. Over-reliance on pain meds because of an acute worsening of chronic pancreatic pain would place the Veteran at risk for accidental overdose. Uncontrolled flare of chronic pain is considered a risk factor for suicide, and overdose is a common method for suicide.

Conclusion: Without additional information, it is not possible to determine the degree to which the Veteran's physical symptoms could have been controlled and/or if timelier health care access could have forestalled this Veteran's death from accidental/intentional overdose.

Case #6, #7, #8, #9, #15, #17, #21, #22, & #25

Omission:
1. In case #6, #7, #8, #9, #15, #17, #22 & 25, it is unclear if the Veterans were advised to present as a walk-in to the Primary Care Clinic to follow-up on chronic medical issues which they could have done on the next regular business day. This would have provided timelier access to medical care.

2. In case #21 it is unclear if the hospital discharge instructions included information on what the patient should do if his primary care appointment was delayed. In general, upon discharge, Veterans are given a one month supply of medication. The Veteran should have been advised to present as a walk-in to the Primary Care Clinic for evaluation of his medications/other issues if he wasn't contacted for an appointment.

3. In case #7 & #25, it is important to note that there currently is no policy for ordering cardiac risk stratification (testing to check for blockages in heart arteries in order to prevent heart attack) when a Veteran with risk factors for heart disease is treated in the ER for non-cardiac chest pain but is found to have no VA PCP assignment. Normally such cardiac risk stratification is ordered by a primary care provider.

Conclusion: Since key information is not known, it is not possible to determine the degree to which delays or lack of quality care contributed to impaired functioning/quality of life or worsening of underlying chronic medical illness.

Case #10
Brain tumors may be malignant (cancerous) or benign (non-cancerous). Some brain tumors can take years to develop while other types can grow in a matter of months.

The symptoms of any brain tumor are dependent on where the tumor is located and to what degree it is interfering with important pathways for speech, memory, thinking ability, movement, or blood/fluid circulation within the brain.

A large brain tumor maybe silent for many years until it interferes with an important brain pathway of functioning. A tiny tumor may be readily apparent if it directly impedes a critical pathway of brain functioning. Interruptions of critical brain pathways produce noticeable symptoms quickly.

The ability of early intervention to affect the prognosis and outcome of a brain tumor is dependent on the size, type, and location of the tumor.

Omission:
1. Blood pressure checks can be done on a walk-in basis in the ambulatory care clinics and do not require a pre-arranged appointment. It is unclear if the Veteran was advised of this process.

2. It is not stated what symptoms the Veteran may have reported to the PCP or if the PCP performed a neurological exam during the first visit and/or ordered a CT head scan. Assuming the patient had reported prior symptoms of slurred speech and dizziness, both a neurological exam and a head CT scan should have been done as part of the prompt work-up needed to determine the cause of the symptoms.

3. It is not stated what type of tumor the patient had. It is unclear if the tumor was aggressive enough to have grown significantly during the delay between requesting an appointment and ultimately reporting his symptoms to a primary care provider (assuming such symptoms were indeed reported during that primary care visit) or to the ER doctor.

4. Although the patient had no recurrence of brain tumor, it is not clear if the patient had any residual effects from the brain tumor or treatment. If the tumor was of the aggressive type interfering with critical pathways, then any residual effects may have been reduced to at least some degree by earlier discovery/intervention when the tumor was smaller. In addition, the size of tumor would have affected the location/amount of brain irradiation and thus potentially increased the risk for side effects/residual effects of radiation treatment.

Conclusion: Even if the prognosis would have been unchanged, the delays in care affected the quality of life for this Veteran.

Case #11
Heart failure is when the heart doesn't pump efficiently on a regular basis.

Compensated heart failure is when the heart muscle has enlarged to pump better and/or medications are being used so that the volume of blood pumped with each heart beat is sufficient to meet the needs of the individual while doing usual, customary activity.

Decompensated heart failure essentially is when the heart cannot pump sufficient blood/fluid to meet the needs of the body's organ systems either at rest or with minimal activity. Symptoms of decompensation can vary depending on the degree of heart failure. Such symptoms can include new or worsening lower extremity swelling, abdominal swelling, generalized edema (swelling), and/or shortness of breath.

An left ventricular ejection fraction is the percentage of blood that a healthy heart pumps out of the left ventricle (main heart pumping chamber) with each heartbeat. A normal ejection fraction is somewhere between 55-70% depending on the individual. An ejection fraction of less than 35+ % makes the individual at risk for life threatening abnormal heart rhythms. An

ejection fraction of 10% in the main heart pumping chamber essentially means only the bare minimum amount of blood to sustain life is being pumped out of the heart on a beat-to-beat basis. Patients with very low ejection fractions are at risk for sudden death from abnormal heart rhythms.

Chronic untreated hypertension (high blood pressure) can cause changes in the heart muscle and circulation that make it harder for the heart to pump in general, especially in the setting of further episodes of high blood pressure.

An echocardiogram is an ultrasound of the heart that evaluates the heart valves, the heart muscle thickness, and the pumping ability of the heart. The most common type of echocardiogram it called "transthoracic echocardiogram" meaning the test is "done across the chest wall". The ultrasound is performed by running an ultrasound wand on the chest wall over the heart. This echocardiogram is neither invasive nor painful. It takes 40 minutes or less to complete.

Omission:

1. Three weeks for an echocardiogram appointment for a patient presenting with new decompensated heart failure is too long to wait. The community standard would have been to do the echocardiogram while the patient was hospitalized. If severe abnormalities are noted in heart structure or pumping ability, then interventions (drugs and/or implantable devices) can be initiated to greatly reduce the patient's risk of sudden death from cardiac failure/lethal heart rhythm. Repeat echocardiograms may be done after discharge to determine if the heart has responded to the medical treatments and is pumping more efficiently.

2. The common echocardiogram takes about 40 minutes or less to complete. It is uncertain why the physicians chose not to perform the echocardiogram while the patient was hospitalized. It is unclear if the echocardiogram division of the Cardiology Clinic had sufficient staffing to do the test in a more timely fashion.

3. The date of echocardiogram interpretation was not included in the OIG report.
It doesn't take 3 weeks to interpret an echocardiogram. The interpretation usually takes 30 minutes or less depending upon the nature of the echocardiogram and the skill of the interpreter. A delay of 3 weeks to have the echocardiogram result entered into the electronic health record (computerized medical chart) means that the VA cardiologist was backlogged on echocardiogram readings and/or there was a delay in uploading the dictated/written report into the computerized medical chart.

4. It is unclear if the cardiologist who interpreted the abnormal echocardiogram tried to initiate contact with the patient, establish a primary care appointment, or establish a cardiology appointment for this patient with dangerously low ejection fraction. In the community, a grossly abnormal echocardiogram finding requires that the cardiologist contact the PCP and/or call the patient immediately.

5. A heart with a left ventricular ejection fraction of 10% is pumping at the bare minimum level to sustain life. If the echocardiogram been interpreted in a timely fashion, the Veteran could have had interventions planned in a more timely fashion and most likely would have avoided decompensation.

Conclusion: Although the OIG concluded prompt medical management "might have prevented his subsequent deterioration", timely treatment had an excellent chance of preventing his subsequent deterioration. The VA did not meet the community standards for medical care.

Case #12 & #14
Localized prostate cancer (present only within the prostate gland) in older men is usually not the aggressive form of prostate cancer found in younger men. Older men can live for years with localized prostate cancer which remains curable or at least medically managed so that the life span is not significantly decreased. However, when such cancer metastasizes (spreads outside the prostate to other areas of the body) the prostate cancer can become quite aggressive and rapidly lead to loss of both quality and quantity of life if not treated in a timely fashion.

Omission:
1. It is not stated if either male was diagnosed with localized prostate cancer or prostate cancer with metastasis.

2. An 8-11 month delay in a patient with metastatic prostate cancer at the time of diagnosis would have significantly changed the course of the care/shortened the life span. An 8-11 month delay in localized prostate cancer diagnosis would not have led to a clinically significant difference for the patient's longevity or ultimate survival.

Conclusion: There was insufficient information provided to determine if the delay in treatment significantly affected the length of lifespan for these Veterans.

Case #13
Like many specialty care services within the Phoenix VAMC, there is a shortage of staffing. There was an administrative push not to establish patients within the specialty care clinics because it would further reduce availability of time slots. Therefore, there was a tendency to accept only the most serious cases for specialty consultation.

Within the VA system, prior to the Phoenix VA scheduling scandal and subsequent monies released for fee basis care, Veterans within the system had to "compete" for a specialty appointment availability and whether or not they would be followed by a specialist. Unstable patients generally were given follow-up specialty care appointments while more stable patients were managed in the primary care clinics.

Omission:
1. It is unclear if a seasoned medical provider within the cardiology service discontinued the consult or if it was closed by a cardiology fellow (in training) or other personnel who had less experience in evaluating the medical record. As per the OIG, this Veteran had "severe cardiac disease" and thus should have established care with a cardiologist.

2. It is not noted if the primary care provider tried to resubmit the consult with additional explanation of why the cardiology consultation was needed.

3. No information is given about the admitting/discharge diagnosis for the second hospitalization. There is also no information regarding what interventions/treatments were required during the second hospitalization. There is no information about whether or not the Veteran had been compliant with his heart medications.

Without details on the second hospitalization, it is not possible to determine the relationship between delayed access to specialty care and subsequent re-hospitalization. Ongoing/regular cardiology care is necessary to promote stabilization of patients with severe cardiac disease.

Conclusion: This Veteran was denied timely access to specialty care that could have prevented his re-hospitalization from worsening cardiac disease. The degree to which the Veteran was affected cannot be established because the OIG did not provide sufficient details to evaluate this case.

Case #16, #24, & #27ds

Omission:
1. After contacting the PVAHCS for an appointment, it is unclear if the Veterans were told that the electronic waiting list was only for primary care providers & not for assignment of mental health providers.

2. It is unknown if these Veteran were told by either registration staff and/or the Primary Care Clinic staff that they could self-refer to the Jade-Opal/C-STAT Clinic for any acute or chronic mental health issues.

3. In case #16, it should be known that the system for communicating between VA Medical Centers is murky and often leads to missed information on Veterans. Ideally, if the East Coast VAMC Suicide Prevention Coordinator (SPC) could not personally speak with the Phoenix VAMC SPC, then the out-of-state staffer should have contacted the Phoenix VA transfer coordinator to ensure information was received and transmitted in a reliable fashion.

4. In case #27, it is unclear if the Veteran was followed by the Suicide Prevention Team at the Texas VAMC and/or if his chart was electronically flagged as a high suicide behavior risk. Although not part of the care at the Phoenix VAMC, it is unclear if this high risk male with

history of four suicide attempts had any follow-up initiated when he missed his November 2013 Texas VA appointment. If the Veteran had been flagged as a high risk for suicide in the Texas VA, the Suicide Prevention Coordinator in Texas should have helped facilitate the transition to the Phoenix VA, assuming the Veteran's relocation plans were known by the Texas suicide prevention team .

5. In any of the cases, if the Veteran was already service-connected for a mental health disorder, he could have directly scheduled an appointment with the Phoenix mental health clinic. (Unfortunately, considering chronic understaffing, a timely mental health appointment may not have been available via that route either.)

6. In the case #27, it cannot be determined if the Veteran would have chosen to present to the Mental Health Crisis Clinic (CSTAT Clinic) prior to committing suicide because it is unclear if the Veteran even knew about the option.

7. In the case #27, it is unclear if appropriate triage was done for Veteran for "ongoing issues" when the veteran spoke to the medical services assistant. Without knowing the nature of the conversation, it is not known if the patient should have been referred to a health care provider with a higher level of triage experience/training.

Conclusion: Delays in accessing appropriate mental health & primary care would be expected to reduce functioning/quality of life. Without the additional information, it is unclear to what degree the delays care impacted each Veteran's life. Timely mental health access would have given mental health providers the chance to intervene to prevent a suicide in at least one case.

Case #18

Omission:
1. The Veteran did not need to have dual enrollment to receive care for his presenting illnesses. The traveling veteran can still get complete care services through the ambulatory care clinics including care for newly diagnosed conditions or decompensated conditions such as elevated blood pressure. The only difference for a traveling vet care is the type of administrative credit the VA receives for completing the Veteran's appointment. Although the Veteran's routine meds are still filled by the home base clinic, the Phoenix VA would have been responsible for filling any new meds, including med adjustments for hypertension.

2. The LPN error highlights some of the deficits in the training for triage nurses in the ambulatory care. An elderly male with recent urinary tract infection, evidence of kidney disease, and poorly controlled blood pressure required further assessment/medical care. A properly trained triage nurse would not have sent this veteran away.

3. There is no information to determine if the Veteran suffered any long term effects/complications his acute worsening of symptoms.

Conclusion: At a minimum, the Veteran was denied access to appropriate health care because of inadequate training of a triage nurse.

Case #19, #20, & #26
Amphetamines and cocaine have dangerous side effects including the immediate development of very high blood pressure that can cause unexpected heart attacks, strokes, or long term problems.

Competent adults have the right to make health care and lifestyle choices for themselves, even when those choices will result in decreased quality and/or quantity of life. A decision to stop substance abuse must be made by the patient. However, a health care provider should facilitate recurrent discussions about substance abuse treatment in order to encourage the patients to consider such treatment.

Omission:
1. There is no notation to determine if these Veterans were referred to Phoenix VA social work services that could have assisted with the provision of information on substance abuse treatment, obtaining medical care, mental health treatment, or other social issues.

2. It is unclear if the Veterans were advised to present as a walk-in to the Primary Care Clinic for blood pressure management or other chronic medical conditions.

3. It is unknown if these Veterans were ever told that they could self-refer to the Phoenix mental health clinic for any acute or chronic mental health issues.

4. There is a notation that the patient in Case #20 had "significant heart disease" but the presence of such significant heart disease is not stated anywhere else in the case. It is unclear if additional follow-up or heart testing was needed but not ordered because of a lack of a primary care physician.

5. For case 19 & 20, there is no notation if the Veterans were interested in following home blood pressures and/or were offered Prosthetics consults for blood pressure machines. This would have been standard treatment for a patient with history of stroke/high blood pressure (case #19) or "significant heart disease"/high blood pressure (case #20).

6. The Veteran in case #19 ultimately had 2 strokes and developed significant loss of vision in both eyes. No long-term complications are listed for the other two cases so it is unknown to what degree delays in accessing care affected their quality of life.

Conclusion: As per the OIG report, these Veterans had clinically significant delays in accessing appropriate care that placed the Veterans at significant risk for medical complications from high

blood pressure (case #19 & 20), heart disease (case #20), and/or persistent substance abuse (#19, #20, #26).

Case #23

Omission:
1. It is unclear if the hospital discharge instructions included information on what the patient should do if his primary care appointment was delayed. The Veteran should have been advised to present as a walk-in to the Primary Care Clinic for refill of his medications/other issues if he wasn't contacted for an appointment. The Veteran could not have controlled diabetes without the medication.

2. In general, upon hospital discharge, Veterans are given a one month supply of medication. It was noted that his diabetes control very poor at his new PCP visit 6 months after discharge. It was not reported if the Veteran ran out of his diabetes medications prior to seeing a primary care provider or obtained meds from a non-VA provider.

3. It is not stated if the Veteran was referred to Endocrinology for an inpatient/outpatient consult to help manage diabetes and high cholesterol. Such a consult could have facilitated follow-up care even without the assignment of a primary care provider.

4. It is not clear if the "blurred vision" the Veteran had was a temporary or permanent finding related to diabetic complications occurring sometime after hospitalization.

Conclusion: At a minimum, the VA did not meet community standards for hospital discharge because the Veteran did not have adequate access to either primary care or specialty diabetic care. The degree to which this affected the Veteran's quality of life cannot be determined by the information in the OIG report.

Case #28

Omission:
1. It cannot be determined if this patient was referred to mental health services at stand-down or if the patient declined such a referral. (Normally, mental health services are routinely offered through a stand-down outreach effort.)

2. It is not stated if the Veteran was aware of the self-referral process to the Phoenix VA mental health clinic.

3. The outcome of that mental health referral is not clear. It is unknown if it resulted in regular care for this Veteran.

Conclusion: As per the OIG report, the delays in this patient's care placed him at risk for violence towards himself or others.

Case #29d
This patient with multiple medical co-morbidities (defined as having 3+ medical problems) had a severe cardiomyopathy (disease of the heart muscle that progressively impairs the heart's ability to pump blood and to maintain a normal heart rhythm).

A patient with severe cardiomyopathy is at high risk for having his heart suddenly stop beating without any warning as the results of a life-threatening heart rhythm known as ventricular fibrillation ("v-fib").

Severe cardiomyopathy is treated with an ICD "implantable cardiac defibrillator". This small defibrillator is placed under the skin permanently with tiny wires that lie under the skin and lead to the heart . These wires monitor the heart rhythm. If the life threatening v-fib rhythm is detected, the device immediately gives the patient's heart an automatic shock which may be able to immediately restart the heart beating/stop v-fib within seconds.

In the event of sudden heart stoppage, immediate defibrillation by an ICD or other type of defibrillator has shown to greatly improve outcomes and survival for the patient. Each minute delay before defibrillation places the patient at risk for permanent brain impairment, heart muscle death, and long term organ failure. When the brain and body are starved for blood supply during prolonged heart stoppage, the chances for meaningful recovery (return to former quality of life) are extremely small.

Omission:
1. The details listed in case #29 indicated a huge delay in specialty care even though the OIG places case 29 after the statement "...OIG identified deficiencies unrelated to delays in the care of 17 patients, including 14 who were deceased."

It is not clear why the month/dates were not specified in the report. Such specificity would have made the creation of a timeline much easier. The delay between initial cardiology consultation and the Veteran's collapse appeared to be at least 4+ months.

A general timeline based on the information in case #29 shows the delay in specialty care. The echocardiogram (heart ultrasound) was done in "late summer" of 2013. Two days later a consult for an ICD was placed. "Two weeks" later a Tucson VA nurse practitioner contacted the patient to schedule the procedure but learned the Veteran wanted metal allergy testing prior to receiving the ICD. (The timeframe was now presumably Fall 2013). Five weeks later (Fall or Winter 2013 though month not specified) the allergy testing was complete. One month later (Fall or Winter 2013 though month not specified) the Veteran was still waiting for an ICD implant to be scheduled. Because of this, the cardiologist sent another note presumably requesting ICD procedure scheduling.

In early 2014 (month not specified) the Veteran had a routine follow-up appointment with his PCP. Within 3-4 days after a PCP appointment, the Veteran collapsed at home. Arriving after an unknown length of time Emergency Medical Services/paramedics diagnosed v-fib. The heart was restarted and the Veteran was transported to the hospital where he survived for 3 days before life support was withdrawn.

The withdrawal of life support indicates the Veteran did not have a good outcome even though resuscitation efforts were successful on the date he collapsed.

2. The reason for the 5 week delay to get an Allergy Clinic appointment was not clarified in the OIG report. It doesn't take 5 weeks to get an allergy patch testing done. Allergy patch testing can be completed within 72 hours. Considering the allergy testing was the Veteran's choice as a mandatory prerequisite to ICD placement, the allergy testing should have been expedited, not delayed for 4+ weeks.

3. It is not clear why the Veteran was not fee-based out to a private cardiologist who could have completed the ICD procedure the same day if Tucson VA facilities were not available in a timely fashion.

4. The whole purpose of an ICD is to immediately shock a heart out of a lethal rhythm. His chances of meaningful survival would have been greatly improved if he had an ICD in place when he went into "v-fib". An immediate ICD defibrillating shock would have lessened the time between detection of v-fib and treatment of v-fib to a matter of seconds. Without the ICD device, the v-fib wasn't treated until after the paramedics arrived in his home. Each minute the Veteran remained in v-fib increased the likelihood of brain tissue loss and/or heart muscle death.

Although OIG concluded "ICD placement might have forestalled that death", the investigators didn't draw any direct connection between delayed access to specialty care procedure and the Veteran's death.

Conclusion: The Veteran died from complications of prolonged v-fib because he didn't have access to appropriate/timely specialty care for ICD placement that would have immediately treated v-fib.

Case #30d

Chronic pain of a stable nature (chronic-continual or chronic-intermittent) is when pain symptoms are occurring/reoccurring in a predictable fashion in terms of location, intensity, duration, and associated symptoms. Although the definitions of pain can be complicated, in practical terms chronic pain is often referred to as pain that is lasts longer than 3 months and/or whose reoccurrence has been in a stable, predictable pattern over many months or years.

Chronic pain can worsen for a variety of reasons including a worsening of the underlying condition, a developing tolerance to pain medication, or a change in activity. That worsening of chronic pain is referred to as "acute on chronic" pain. There should be an evaluation of why chronic pain is getting worse.

Acute pain or "new pain" is usually defined as new onset within the last 3 months and whose description and occurrence is not yet predictable. When the new pain is severe and/or unrelenting, prompt evaluation is required to rule out any significant underlying serious medical conditions causing the pain.

One of the basic duties of nursing triage is to evaluate the common descriptors of pain including location of pain (anterior chest, upper abdomen, right lower abdomen, etc.), duration of pain (hours, days, etc.), quality of pain (sharp, dull, crampy, burning, etc.), intensity of pain (mild, moderate, or "worst ever"), and associated symptoms (nausea, vomiting, localized weakness, bleeding, etc.).

A "perforated bowel" occurs when a hole occurs somewhere in the wall of the intestines. This hole allows leaks bacteria, fluid, and air into the abdomen. This air can often be detected by x-rays of the abdomen that shows the air collection as a "black area" in the top or side of the abdominal cavity.

When bacteria leak into the abdominal cavity, infection can spread throughout the body and affect all organ systems including the heart and lungs. The body can have a shock reaction to infection and symptoms can include hypothermia (low body temperature below usual 98.6 degrees Fahrenheit), fast heartbeat, and/or low blood pressure. This widespread infection can cause become a "septic shock" syndrome" which causes failure of multiple organs in the body and is associated with a significant risk of death.

The treatment for perforated bowel is usually prompt surgical repair of the perforation as well as antibiotics to treat infection.

In this Veteran's case, four days after starting a strong pain medication to control new "torso pain", this Veteran died from complications related to having a bowel perforation.

Unfortunately, because of poor VA medical record documentation, it cannot be conclusively established if the new "torso" pain was related to the pending bowel perforation. However, as per the OIG report, a new location of severe pain should have warranted prompt evaluation which unfortunately was not done. It is clear the Veteran had improper triage assessment of his new pain.

In this clinical context, there should be a high clinical suspicion that the torso pain was actually early signs of chest/abdominal pain associated with pending perforated bowel. Usually patients will experience new/worsening pain for a few days prior to the actual perforation.

When the Veteran did present to the ER and was discovered to have a perforated bowel, the surgical intervention/operation required to treat this Veteran was significantly delayed for reasons not listed in the OIG report. Normally, large perforations and/or delayed surgical repair of the perforation are associated with worse outcomes including overwhelming infection and death.

Omission:

1. There should have been a better health care provider triage assessment of his new onset pain when he called his PCP requesting stronger pain medication for "torso pain". Without adequate descriptors of the pain characteristics, it is not possible to rule out a serious underlying medical condition causing the pain.

2. The patient's chronic pain was located in his neck. Presumably the "torso" pain was in a different location but the word "torso" is too vague to determine the exact location (back, upper chest, lower chest, abdomen, etc.). As per the OIG report, a new location of severe pain should have warranted prompt evaluation. There is inadequate information to determine if the "torso pain" was actually early signs of abdominal pain associated with pending/actual perforated bowel.

3. The report doesn't state why there was a 4 hour delay for the surgical consult. The delay could have been from one of several factors:

a. Presence of a delay in reading the CT scan of 2-4 hours, assuming the CT scan was done with oral contrast (fluid the patient drinks to help highlight the intestines) that takes 2 hours to circulate through the GI tract.(CT scan normally only takes a few minutes to interpret and the report is usually available within one hour. Radiologists usually notify ER physicians promptly if there are abnormalities like a perforated bowel.

b. The CT scan was interpreted in a timely fashion but competing emergencies in the ER/inadequate ER staffing to follow-up promptly on test results.

c. The surgical consult was ordered telephonically earlier but the ER physician was delayed in entering the actual physical order. (When I worked in the ER, there were difficulties with getting prompt surgical evaluations because of surgical staffing issues/competing surgical resident duties.)

4. It is unclear if the physical exam in the ER would have indicated the need for a 3 way abdominal series of x-rays that could have detected free air rapidly. This process would have taken a few minutes in the radiology suite to perform instead of the 2+ hours prep time needed to perform an abdominal CT scan with oral contrast.

5. The OIG concluded that "earlier diagnosis and treatment might have altered the outcome in this case." However, assuming the new torso pain was related to the pending bowel

perforation, more thorough triage & prompt assessment/treatment definitely would have prevented the course of clinical deterioration that led to this Veteran's death. Earlier surgical intervention was important because early surgical intervention is one of the keys to preventing complications leading to death.

Conclusion: A Veteran did not have timely access to appropriate medical care that would have enabled the earlier diagnosis/treatment needed to vastly improve the outcome in this case and greatly reduce the risk of untimely death.

Case #31d

This Veteran died of metastatic prostate cancer that was not treated during the 7 month period that the VA failed to address an abnormal lab test indicating the return of prostate cancer. By the time the lab test was repeated, Vet had persistent back pain consistent with significant spread of prostate cancer to the bones in his lower spine. Although treatment for prostate cancer was initiated, this Veteran's cancer had progressed too far. The Veteran eventually died in hospice after an unknown amount of time receiving prostate cancer treatment.

The prostate gland releases a chemical in the blood known as the "prostate specific antigen" (PSA). No other part of the body produces this chemical.

There are ranges of "normal PSA" level depending upon age, ethnicity, and underlying prostate size. However, in general, the average normal prostate level in a healthy male without prostate cancer is between 0-4. Localized prostate cancer can cause the prostate level to be slightly elevated. Metastatic (wide spread) prostate cancer can cause the values to rise rapidly from 10+ up to 900+.

When a man has prostate cancer only in the prostate gland, one possible treatment is to remove the prostate gland in an attempt to completely rid the body of prostate cancer. If a prostate gland is removed, then a male's PSA level should fall to zero or "undetectable" levels.

Unfortunately, sometimes microscopic amounts of the cancerous prostate cells will spread to other locations in the body but can't be detected by available medical tests. As those cancerous prostate cells multiply rapidly in other areas of the body, they eventually will produce enough PSA to produce measurable levels of PSA again.

Any increase in PSA after the prostate gland is removed indicates that prostate cancer present in other body areas such as the bones. When a previously undetectable level rises, the patient must have prompt medical evaluation by a specialist who deals with prostate cancer such as a urologist.

Although prostate cancer limited to only the prostate gland generally grows slowly, metastatic prostate cancer can rapidly spread and significantly shorten both the quality and quantity of the patient's life.

Compensation & Pension (C&P exams) are exams performed only to indicate whether or not a Veterans medical condition may or may not be related to military service. The purpose of C&P exams are not to have the C&P provider treat the underlying condition.

Omission:
1. It is unclear if the C&P provider told the Veteran the importance of seeking immediate urological care for an elevated PSA when he should have had an undetectable level of PSA.

2. It is not stated whether or not the C&P provider attempted to notify the Veteran's VA PCP about the abnormal/unexpected PSA elevation.

3. Earlier treatment of the prostate cancer before it aggressively spread to multiple bones could have forestalled the patient's death by months/years and certainly would have improved quality of life.

Conclusion: Because of unavailability of scheduled urology appointments and subsequent missed abnormal prostate lab finding, this Veteran was denied timely access to specialty care/treatment that likely would have forestalled the patient's death by months/possibly 1+ year and certainly would have improved quality of life.

Case #32d
This Veteran was initially admitted to the VA hospital to work up liver abnormalities that, in retrospect, were indications of advanced cancer. The Veteran was discharged home with the expectation of an outpatient biopsy to confirm the diagnosis of suspected cancer. There is no reason given for why the biopsy was not done while the patient was hospitalized. The contact information was not accurate on discharge so the staff couldn't reach the patient to schedule the outpatient follow-up. Ultimately, the biopsy was not done because the patient's symptoms/exam were consistent with widespread cancer of some type and the risk of doing a biopsy was too great in this very ill Veteran.

The OIG report is unclear but implies the Veteran presented at least once to the ER after the initial VA hospitalization and at least once to the primary care clinic. During one of those visits (site unknown) he was not admitted even though the Veteran had intractable (severe/unrelenting) abdominal pain and probable metastatic (widespread cancer) disease. The final VA visit a week later (location of visit not specified) resulted in an admission to the hospital and death in a hospice unit approximately 4 days later.

Omission:
1. Staff are supposed to confirm the patient's contact information on admission and at discharge. Unfortunately, per the case details, the "listed contact information was incorrect" which prevented scheduling a follow-up appointment.

2. Based on the case details, this Veteran had advanced/aggressive cancer when he was admitted to the VA hospital initially. Although biopsy was not done for unclear reason, his clinical presentation must have been consistent with advanced cancer because that was the clinical presentation on an outpatient visit (ER versus primary care clinic) within 2 weeks. Timelier follow-up with a cancer specialist could have facilitated discussion on the prognosis as well as the benefit of hospice care for his remaining 2-3 weeks of life. As the events transpired, the Veteran was only on hospice for a maximum of 3 days before death.

3. It is unclear why this Veteran with "intractable abdominal pain and probable metastatic" cancer was not admitted to the hospital when he presented with these symptoms on an outpatient visit so this severe abdominal pain could be treated. There are no details to determine if the Veteran refused admission or if the admission was never offered.

Conclusion: Although earlier diagnosis/biopsy would not have prevented the death from wide spread cancer, this very ill Veteran was denied the timely opportunity for palliative care services that could have ensured better quality of life in his final weeks before death.

Case #33d
When IV iron is given, a patient usually has severe iron deficiency. A common cause of iron deficiency in middle-aged males is chronic bleeding located somewhere in the gastrointestinal tract (esophagus, stomach, or intestines).

When severe anemia is noted and/or there is significant blood in the stool, the patient requires special tests to locate the site of the bleeding inside the GI tract. Upper GI endoscopy and colonoscopy allow the physician to see inside the GI tract to locate a source of bleeding.

This Veteran had an aortic valve replacement which required long term use of blood thinners to stop clots from forming on the valve. If he stopped the blood thinner, he would be at risk for dying from a clogged valve or having strokes from clots moving to the brain.

This Veteran received an IV iron infusion during hospitalization for unclear reasons but presumably was related to severe anemia based on the case context. He was on a medication that thins the blood and will cause bleeding to be prolonged. He was at high risk for having further significant bleeding episodes because of his self-described blood in the stool.

Low blood pressure and dizziness are symptoms that can have many causes. However, both of these symptoms can be seen with sudden, severe bleeding.

Omission:
1. There is no notation if and/or when the patient sought non-VA care for the low blood pressure reading and dizziness. It is unknown if the patient appropriately contacted a non-VA physician even if the patient was not contacted by the VA health care provider.

2. It is not clear why this Veteran did not have the upper GI endoscopy or the colonoscopy while he was hospitalized. Assuming the Veteran would consent to the procedure while hospitalized & he was medically stable, those procedures would not have been delayed in the community for patients with this presentation.

3. The cause of death is not listed. It is unclear if the cause of death was related to GI bleeding or other problem. Based on his blood thinner use and presence of blood in the stool, this patient was at high risk for future significant GI bleeding.

4. It is unclear if the PCP had sufficient staffing to be able to contact the patient in a timely fashion.

Conclusion: I agreed with the OIG's opinion that this Veteran should have received at least immediate telephone follow-up. However, without the cause of death and other details, it is not possible to determine if there was any clinical significance between care delays (including the lack of GI procedures while hospitalized) and this Veteran's death 5 weeks after reporting feeling weak and dizzy.

Case #34d
While hospitalized for a new stroke work-up, this middle-aged Veteran who had risk factors for lung cancer was found to have an abnormal "large density" (a big abnormal area of tissue) on his chest x-ray. No CT scan or other study was done to determine what might be the cause of the mass. The Veteran was discharged home and readmitted 6 weeks later because of shortness of breath. After being diagnosed with lung cancer during this second hospitalization, the Veteran was discharged to hospice and died a few days later.

Advanced non-small cell lung cancer can be aggressive and lead to rapid deterioration in later stages.

The purpose of palliative care services for a patient with grossly advanced cancer is to manage symptoms and address the psychosocial and spiritual issues prominent in the final stages of life so that quality of life is preserved until death.

Omission:
1. Normally, a middle aged male smoker with a new large lung abnormality is presumed to have a cancer diagnosis until proven otherwise. In a non-VA facility, a physician would have initiated a work-up to include at least an initial chest CT scan prior to discharge. If significant chest CT scan abnormalities were discovered, there would be a need for rapid referral to a specialist for evaluation. If advanced, non-curable cancer was present, the palliative care/hospice options would have been appropriately discussed with the patient.

2. Although his lifespan likely would not have been prolonged, earlier evaluation would have allowed more timely hospice services to ensure the highest quality of life/symptom control was preserved during the final weeks, not just days, of this Veteran's life.

Conclusion: This Veteran was denied timely access to diagnostic studies that would have indicated advanced/incurable lung cancer. Although his lifespan may not have been prolonged in the setting of advanced lung cancer, earlier evaluation would have allowed more timely hospice services to preserve quality of life during the last 2 months before death.

Case #35ds

Potential Omission/Comment: *The information presented in the paragraph below is given based upon limited knowledge of a Phoenix VA patient outcome that matches the details provided by the OIG for case #35. If this is the same patient then following information was a glaring omission in the OIG report. Even if it is not the same patient, this case is important to highlight how a single barrier to health care access can have cascading consequences.*

A Veteran with underlying depression called his family to ask for help managing his worsening mental health symptoms. This Veteran initially presented with his family members to the walk-in mental health clinic for assessment and care. The Veteran had never been enrolled at the Phoenix VA. Because the Veteran denied having an acute crisis when he presented to the front desk, he was diverted to the Enrollment & Eligibility Clinic for "hours". Apparently he did not have a formal nursing triage assessment prior to this diversion. The Veteran returned too late in the day to be seen by mental health staff in the clinic. He then was diverted to the ER, again waited a lengthy time to be seen, and eventually had a mental health assessment by the psychiatric nurse. By the time he was seen by the ER staff, the Veteran wanted to go home/declined admission and denied any suicidal or homicidal thoughts. He agreed to return the next day to the same mental health clinic he had attempted to see earlier. The Veteran committed suicide the next day.

At that time Veterans presenting to the Jade-Opal walk-in mental health clinic would be diverted to Eligibility and Enrollment Clinic if they had never been enrolled in the PVAHCS before and assuming they were not deemed to be having an acute crisis like suicidal or homicidal thoughts. Those Veterans would not undergo formal nursing triage assessment prior to being sent to the Eligibility and Enrollment Clinic. Such diversion is against community standards for acute mental health treatment.

Conclusion: Although it is unknown if the suicide could have ultimately been prevented, the registration process in the mental health clinic served as an impediment to good patient care for this Veteran with self-reported worsening depression.

Case #36ds
This Veteran with multiple medical problems had both depression and a history of chronic pain that was not well controlled. When his pain significantly worsened, he made statements to various VA health care providers indicating his pain was severe that he was feeling like "it might make him suicidal" and that he "could cry [because of pain]". However, the Veteran denied having any overt suicidal thoughts. The OIG did not give any indication that the PCP provider responded to this Veteran's message(s) regarding the worsening pain control.

When the Veteran did present in person to the walk-in PCP clinic to get treatment for the pain, the Veteran apparently was only referred to mental health to address the side effect of pain (depression) and did not get medical interventions to relieve the pain. The same day, the patient called the National Suicide Prevention Hotline to complain of "severe and chronic pain unresponsive to treatment" and complained that his PCP was not responding to his requests for contact. A consult was placed to the suicide prevention coordinator but the consult was closed, presumably because the Veteran indicated the issue was related only to severe/unrelenting pain and denied having suicidal thoughts. Within one week the Veteran committed suicide without ever having any medical intervention to control his unrelenting, severe pain.

As previously mentioned, chronic pain of a stable nature (chronic-continual or chronic-intermittent) is when there is a condition causing pain where the symptoms of that pain are occurring/reoccurring in a predictable fashion in terms of location, intensity, duration, and associated symptoms. Although the definitions of pain can be complicated, in practical terms chronic pain is often referred to as pain that is lasts longer than 3 months and/or whose reoccurrence has been in a stable, predictable pattern over many months/years.

Chronic pain can worsen for a variety of reasons including a worsening of the underlying condition, a developing tolerance to pain medication, or a change in activity. That is referred to as "acute on chronic" pain. There should be a medical evaluation of why chronic pain is getting worse.

As noted earlier in this section, part of basic nursing triage is to evaluate the common descriptors of pain including location of pain (anterior chest, upper abdomen, right lower abdomen, etc.), duration of pain (hours, days, etc.), quality of pain (sharp, dull, crampy, burning etc.), intensity of pain (mild, moderate, or "worst ever"), and associated symptoms (nausea, vomiting, localized weakness, bleeding, etc.).

Although pain is felt physically, chronic uncontrolled pain is associated with increased risk of sustained anxiety, stress, depression, and increased risk of suicide. In addition, psychological factors play a role in the perception/sensitivity to pain. However, for individuals with uncontrolled pain, any implication that the pain is "just in their head" is demoralizing.

Omission:
1. The data from the triage assessment by the registered nurse was not clarified in the OIG report. However, an initial response to refer the patient to a mental health provider is not appropriate for new acute-on-chronic pain issues.

2. As per the OIG, this patient should have been identified as having a high risk for suicide because of underlying depression. However, even if this had been done, it is clear that the impetus for the suicidal thoughts was unremitting, severe pain which was never addressed by the PCP.

The OIG did not draw a connection between the lack of PCP response/treatment of acutely worsening unrelenting pain and the Veteran's subsequent suicide.

Conclusion: The Veteran did not receive appropriate/timely care for his unrelenting, severe pain that served as the impetus for his suicidal thoughts and ultimate suicide.

Case #37d
A lesion is essentially an abnormal area of tissue in the body that can occur because of injury, disease, or other factor that causes change in the formation of the tissue. A lesion can be of any size.

A benign (non-cancerous) lesion in the lung often will remain relatively stable in size over the course of 3 months, 6 months, or 12 months. A cancerous lesion in the lung will often grow rapidly in size during that same time frame because the cancer cells are constantly multiply at faster rates than healthy cells. When following a "lung lesion", repeat chest x-rays or chest CT scans are done at intervals to detect any abnormal changes in size that may indicate a higher likelihood that the lesion is cancer.

Although melanoma is commonly referred to as a "skin cancer", it is actually a cancer of nerve cells. Nerve cells are present throughout the body. Although melanoma is classically described by its appearance on the skin, it can actually occur in almost any area of the body where there are nerve cells including the lung and brain.

Melanoma is extremely aggressive and even a small lesion can spread very rapidly throughout the body. Aggressive evaluation and treatment is needed to prevent melanoma from becoming widespread.

In the case of this Veteran, ten months after a questionable biopsy of a lung mass suspicious for cancer, a Veteran died of metastatic melanoma (type of cancer) that can spread rapidly throughout the body. Because there was no definitive biopsy/autopsy details to determine if the lung mass was melanoma or not, the OIG wrote "the death may not have been related to the lung mass".

Omission:
1. There are no autopsy details to determine if the lung mass was melanoma or not. However, when a suspicious mass is noted on chest x-ray and then 10 months later the patient is found to have metastatic cancer in the brain, the clinical suspicion is high that the original lung mass was cancer.

2. Although the OIG acknowledged the management of the mass was inadequate, it wasn't clear if the OIG followed due diligence to determine how likely the lung mass was cancer. The private hospital likely would have done a chest x-ray and a CT scan of the lungs prior to taking the patient to surgery. A comparison of the radiology reports from the private hospital to the x-ray/CT scan of lungs from the VA hospital 10 months earlier should have been done. A significant difference in the appearance of the lung lesion would be indicative that the lung lesion was most likely cancerous.

The patient had comprehensive palliative care at the PVAHCS for 6 months prior to his death. If a chest x-ray or CT scan of lungs was done during that timeframe, a comparison could be made to determine if the original site of the lung lesion had enlarged consistent with cancerous growth.

3. If the lung mass was melanoma, then the prognosis was terminal and death was inevitable from the melanoma. Although his lifespan may not have been prolonged in the setting of advanced cancer, earlier diagnosis would have allowed timelier referral to palliative care/hospice services to increase quality of life during the Veteran's remaining lifespan.

Conclusion: This Veteran was denied timely access to follow-up medical care that may have detected a possible aggressive cancer. Assuming the lung mass was incurable melanoma, the lack of follow-up care denied him the ability to receive medical interventions that would have contributed to greatly increased quality of life in his remaining lifespan.

Case #38d

Comment: *Until recently, the PVAHCS mental health clinic has been grossly understaffed for years. Timely follow-up calls for missed appointments were generally not possible. The OIG described many of the mental health care deficiencies in its report.*

Case #39ds
This homeless Veteran had a history of PTSD, 3 suicide attempts requiring hospitalization in the prior 2 years, and schizoaffective disorder which is a serious psychiatric diagnosis predisposing him to irrational thoughts, paranoia, and hallucinations.

At the time of presentation to the ER, this patient was having intense emotional stressors as evidenced by the comment that he " hates life and it is so stressful that he doesn't want to be in it". He also reportedly felt suicidal because he could not afford to stay at his motel. While inability to pay for a motel is normally not a reason for suicidal thoughts, this Veteran was predisposed to irrational thoughts based on his psychiatric diagnoses and could have easily felt overwhelmed at the thought of living on the streets again.

Despite his psychiatric history and intense current social stressors, the Veteran inexplicably was rated as having a low risk for suicide. Since the Veteran was not appropriately admitted to an inpatient unit where he his risk of completing suicide would have been almost zero, the Veteran found himself again in an unstable environment. He committed suicide the next day.

Recognizing the Veteran's risk factors for suicide and acute psychiatric instability, the OIG wrote psychiatric admission "...would have been a more appropriate management plan" for this patient with a history of "multiple suicide attempts, psychosis, homelessness". However the OIG failed to draw a connection between inappropriate discharge from the ER and this unstable Veteran's suicide the next day.

Omission:
1. It is unclear why the mental health consultant rated the Veteran's risk for suicide as low. As evidenced by the OIG's written comments, the Veteran did not have adequate protective factors to prevent suicide and had multiple risk factors for committing suicide. The patient should have scored higher on the standard suicide risk assessment that is done for patients with suicidal thoughts at the Phoenix VA.

2. Admission to the inpatient psychiatric unit would have enabled the Veteran to have a safe, therapeutic environment where the risk of committing suicide would have been low. While admission may not have prevented suicide in the longer term suicide, more appropriate disposition to an inpatient mental health bed would have prevented the suicide in the immediate short-term timeframe. It is unclear if admission was offered to the Veteran at any point.

3. Even though he was not admitted, it is not stated if this Veteran was offered/received social work services to assist with social/financial/housing resources to deal with his obvious, self-reported stressors.

Conclusion: Lack of appropriate psychiatric admission for a patient with multiple risk factors for suicide enabled a death from suicide within 24 hours from point of last VA mental health/ER contact.

Case #40ds (almost certainly a suicide but OIG phrasing vague)
This Veteran had a history of suicidal thoughts, 7 former psychiatric hospitalizations for mental health instability, and a history of hurting himself. He had been admitted to the Phoenix VA

inpatient psychiatry unit because of suicidal thoughts, thoughts of harming his brother, and self-reported difficulty controlling his rage.

Although the Veteran denied suicidal/homicidal thoughts on the day of discharge, his behavior/demeanor on the inpatient ward and at the family conference indicated the Veteran was not yet stabilized on psychiatric medication.

The Veteran was discharged home presumably by his insistence. Neither the family nor the VA inpatient psychiatry staff tried to block this discharge by requesting the Court grant permission to keep this patient involuntarily until his meds could be stabilized.

Two days later, the Veteran was found dead from a "possible overdose on medication" which in this context is consistent with suicide. Even if this was an accidental overdose, the Veteran's psychiatric presentation indicated very poor impulse control that often predisposes an individual to make irrational decisions such as overuse of medication.

The OIG wrote it "would have been prudent" to continue the inpatient hospitalization (either voluntary or involuntary) for this Veteran. However, the OIG did not draw a connection between lack of "prudent" continued psychiatric inpatient care and the death of this unstable Veteran from suicide two days later.

Omission:
1. Failure to prudently continue inpatient psychiatric care resulted in discharge of a Veteran to an unmonitored outpatient setting wherein the Veteran died from overdose 2 days later. If the Veteran would have remained on the inpatient psychiatric unit, his risk of intentional death would have been almost nonexistent.

2. No explanation was given to determine why petitioning was not attempted by the mental health staff. Psychiatric petitioning for involuntary admission is a routine procedure for mental health providers. Petitioning is done if the Veteran who is refusing psychiatric treatment is deemed a danger to himself or others. While the petition is being officially reviewed by the proper legal authorities/court, the patient can be placed on temporary medical hold that will prevent the patient from leaving the mental health ward until the ruling on the petition is made.

Conclusion: Premature discharge from a psychiatric ward for an unstable patient with multiple risk factors for suicide enabled a death from suicide within 48 hours from point of last VA mental health contact.

Case #41d
In the OIG report, this Veteran is described as having "significant dementia" and "severe cognitive impairment" (severe loss of ability for higher levels of thinking). His cause of death

was from chronic "hypertensive and arteriosclerotic cardiovascular disease". This means he died from heart disease caused by chronic high blood pressure and chronic cholesterol disease.

There are various types of dementia with different patterns of presentation & progression. Mild dementia can have very minor symptoms such some forgetfulness. Symptoms of severe dementia can include loss of ability to remember simple details/events, understand concepts, and make good, rational decisions.

Adult Protective Services (APS) in each state are charged with the responsibility of protecting at risk/vulnerable adults who have diminished physical, mental, and/or financial capacity to protect themselves against abuse, exploitation, neglect from others, or self-neglect. The goal is to help the at-risk/vulnerable adult live as independent a life as possible by connecting the adult with appropriate community resources & services.

Omission:
1. Based upon the description given by the OIG, the Veteran did not have the capacity to access long-term medical services that may have forestalled his death from chronic disease. The Veteran likely would not have been able to seek short-term or emergency medical services needed to treat new onset of heart disease symptoms.

2. It is not reported if this Veteran with "severe cognitive impairment"/significant dementia was ever reported by any VA employee to the Arizona APS. That agency could have assessed the Veteran's welfare and evaluated what services the Veteran might have needed to live safely & appropriately access medical services. Because the Veteran had not been seen by case manager since 2008, then diagnosis of significant dementia and his lack of usual resources were known at least 5 years prior to his death because his chart had not been updated after 2009. During those 5 years, it is expected that any type of dementia would have worsened.

Conclusion: Without additional information, it is unclear if the VA case manager/other VA staff fulfilled a mandatory obligation to place a report to Adult Protective Services so that this vulnerable adult with severe dementia could access community resources to enable a higher quality of life and receive medical care for his chronic medical problems.

Case #42ds
After completing a month long inpatient substance abuse treatment program, this Veteran apparently was discharged without any referral for ongoing mental health care to support his early sobriety/psychiatric issues common to early recovery. Although medical care for chronic non-psychiatric health care issues was scheduled for 3 months after discharge, the Veteran committed suicide 2 weeks before that appointment.

Patients with substance abuse disorders have a high rate of concurrent psychiatric disorders such as PTSD, major depression, anxiety, or bipolar disorder. Having both a substance abuse problem and a psychiatric diagnosis is commonly referred to as "dual diagnosis". The patients

often use the substance (alcohol, cocaine, methamphetamines, etc.) to order to self-medicate and control the symptoms of the underlying psychiatric issue.

Successful remission of substance abuse problems requires a detailed plan to address the immediate, short-term needs. It also requires a complex plan to maintain long term recovery. Mental health follow-up/mental health crisis numbers would have been a standard part of mental health discharge at non-VA facilities.

The highest risk of relapse is often in the immediate phases of recovery especially when the Veteran has dual diagnosis. If the Veteran abstains from the drug, he is no longer self-medicating for the psychiatric disorder. In the absence of appropriate mental health support, the Veteran is at risk for acute worsening of his underlying psychiatric symptoms. The high degree of self-blame/guilt with relapse can also lead to profound depression/suicidal thoughts.

Omission:
1. It is unknown if this Veteran had a co-existing mental health disorder such as PTSD, anxiety, major depression, etc. that would have made him at higher risk of acute worsening of mental health issues during early recovery phases/sobriety.

2. The OIG wrote "this patient should have had follow-up established with a PCP or mental health provider sooner than the 12 weeks that were planned [for a PCP appointment]." The OIG did not list the timeframe for any type of appointments for mental health care. This would indicate that there were no mental health appointments scheduled upon discharge from the PVAHCS Substance Abuse Residential Rehabilitation Treatment Program.

3. It is not noted if the written discharge plan included information on the self-referral process to the Phoenix VA mental health clinic for issues such as anxiety, depression, and substance abuse relapse.

4. If the VA failed to establish an appropriate mental health follow-up plan upon discharge, then the VA missed the opportunity to support/stabilize the Veteran during the early recovery phase.

5. At the time this Veteran likely had the Suicide Risk Assessment form completed, a suicide risk of "low or nil" did not require any suicide prevention plan to be established.
Even though the Veteran was rated to have "nil or low" suicide risk at discharge, a mental health provider should have anticipated that ongoing mental health services would have been necessary to support the patient's recovery. Although stressors had to have occurred between the discharge date and the Veteran's suicide 10 weeks later, without a mental health follow-up plan, the Veteran would have been much less likely to be able to handle the stressors.

Conclusion: If there was no mental health discharge follow-up plan, then the VA failed to meet the community standards for mental health treatment. In the absence of an appropriate

discharge plan, there is a relationship between inadequate mental health post-discharge care and his subsequent mental health deterioration resulting in suicide.

Case #43 & #44
No gaps in information noted.

Case #45
The OIG described this Veteran as "ill hypertensive patient" who had multiple risk factors for complications including diabetes, high blood pressure, and heart disease.

Urosepsis is a widespread infection of the blood that occurs when a urine/kidney infection spreads to the blood stream. The risk of urosepsis can be reduced by early treatment for a urinary infection. There is a higher risk of complications including death in older patients and/or diabetic patients who develop urosepsis.

Performing basic vital signs should be done as part of a nursing triage assessment when the patient arrives for a walk-in appointment to the PCP clinic.

Comment:
There is a disparity between the primary care providers training and skill sets based upon whether the provider is a physician (M.D. or D.O.), nurse practitioner (N.P.), or physician assistant (P.A.). Physicians must complete a 4 year physician doctorate program and 3+ years of continual training in medicine. Depending upon the program, nurse practitioners complete 2+ years of training via a master's degree in nursing. Physician assistants generally complete a 2+ year program.

In the VA system, these providers are considered to be independent practitioners regardless of training. All providers should be equally qualified to manage simple, uncomplicated problems or stable, chronic problems. Unless there has been additional study/training completed, primary care for complicated patients with multiple co-morbidities or urgent care of extremely complicated ill patients is outside the scope of practice for many nurse practitioners and most physician assistants.

Patients in the VA are assigned according to availability of the provider with no regard to the ability of a provider to handle the complexity of the patients.

Omission:
1. This Veteran had diabetes that placed him at risk for serious infection. No details were provided regarding the training/skill level of the nurse who didn't do vital signs or the provider who didn't record a complete physical exam or order studies for this "ill hypotensive" patient.

Conclusion: As per the OIG, this Veteran denied adequate evaluation of his medical illness. Appropriate triage and evaluation could have prevented his subsequent deterioration and hospitalization.

Persistent PVAHCS Issues Having Implications for Other VHA Facilities

The 8/26/14 VA OIG Report has given the Phoenix VA Health Care System (PVAHCS) the opportunity to re-examine itself and identify areas needed for improvement. Invariably the new influx of Veterans will strain resources within the PVAHCS. These deficiencies need to be proactively addressed so the Phoenix VA can meet and exceed its obligations to our nation's current and future Veterans.

Just as the scheduling irregularities and Electronic Wait List (EWL) issues were not unique to the Phoenix VA, other problems within PVAHCS have the potential to be mirrored in sister facilities throughout the nation. The information included in this section is intended to serve as a potential springboard for further discussion and positive change in not only the Phoenix VA Health Care System but also throughout the Veteran's Health Administration (VHA).

1. Patients in at the Phoenix VA usually are assigned according to availability of the provider with no regard to the ability of a provider to handle the complexity of the patients.

There is a disparity between the primary care providers training and skill sets based upon whether the provider is a physician (M.D. or D.O.), nurse practitioner (N.P.), or physician assistant (P.A). Physicians must complete a 4 year physician doctorate program and 3+ years of continual training in medicine. Depending upon the program, nurse practitioners complete 2+ years of training via a master's degree in nursing. Physician assistants generally complete a 2+ year program.

In the VA system, each of these providers are considered to be an independent practitioners regardless of training. As an independent practitioner, the provider can practice without the oversight of a physician. All providers are qualified to manage simple, acute problems or limited/ stable chronic problems. However, unless there has been additional study/training completed, primary care for very complicated patients with multiple co-morbidities is outside the scope of practice for many nurse practitioners and most physician assistants.

Patients in the VA are assigned by non-medical staff according to availability of the health care provider's time slots with no regard to the ability of that provider to handle the complexity of the patients.

2. There is no standardization of triage nurse training anywhere in the VHA system including the Phoenix VAMC.

Appropriate nurse triage is a cornerstone for high quality patient care. The triage skills of the nurse are used to assess patient complaints and requests in order to help the patient access the

next appropriate step in health care. In addition, nursing insight can be a valuable key to understanding the psychosocial needs of the patients and families.

Currently, the quality of the nurse triage is variable at the Phoenix VAMC. Some nurses are highly skilled through many years of nursing practice and have excellent clinical insight and judgment. Other nurses do not have the experience or training to appropriately triage complex patients or recognize when reported symptoms may require urgent/emergent intervention by other health care providers.

Therefore, when patients come to the mental health clinic, emergency department, or primary care clinics to be seen, the variable quality of triage means there is no consistently applied standard of assessment and thus no consistency in patient outcomes. Patients will potentially encounter significant barriers to accessing the next level of proper care efficiently.

3. Appointment requests generated over the phone or in person at the PVAHCS Eligibility Clinic are not evaluated by a health care professional to determine urgency.

When appointment requests are received, the decision for scheduling is in the hands of Health Administration Service (HAS) employees who do not usually have any health care background. There is no process of routinely reviewing the requests to triage/prioritize appointments on the basis of medical need/urgency. As a result, some Veterans who require more urgent scheduling based on medical need are not identified or scheduled in a timely manner.

4. Within the PVAHCS the primary responsibility for chronic pain medication management is commonly left to the primary care provider and not a pain management specialist.

Narcotics for chronic pain control are considered high risk medications to use on a regular basis. Health care providers are obligated to closely follow patients on high dose narcotics. Chronic pain control management includes continual patient education, appropriate narcotic selection, dose adjustments with titration, and evaluation of pain control and side effects.

The Phoenix VA has an amazingly talented pain management team. However, it is not staffed to be able to handle the large number of Veterans on chronic narcotics who require the team's expertise and direct, face-to-face services. By default, the primary care providers, many of whom are already overwhelmed with high acuity patients, must manage those patients.

In the community setting, patients on high dose/chronic narcotics are followed by a pain management specialists.

5. Within PVAHCS, primary care providers are struggling to manage oversized patient panels (a group of patients that are assigned to a provider) or with panels that do not have a balanced mix of patients.

Outpatient medical acuity is essentially the intensity of medical care needed on a regular basis to meet the patient's day-to-day the health care needs and promote quality of life.

Overall, the Veteran population is a very complex/high acuity group of patients to manage because of unique exposures/injuries during military service as well as significant frequency of medical co-morbidity (having 2+ significant medical problems in one patient). Multiple co-morbidities greatly complicate medical management of patients because any one disease process can make the individual more likely to suffer complications or worsening symptoms from his/her other medical problems. The clinical decision-making process is often extremely intense in order to effectively manage a cluster of medical problems presenting in one patient.

VA recommended panel limits can be up to 1200 patients per primary care provider (physician, nurse practitioner, or physician assistant). Within the PVAHCS as well as sister facilities, some provider panels can be 10-20+% over the recommended limit and effectively very thinly stretch the provider to cover the increased load.

Additional patients over the recommended panel size greatly increases the daily clinical workload. Inevitably, the provider has to address a higher number of patient requests/telephone messages, meet increased numbers of potential walk-in requests, fill more medication refills, review greater quantity of labs, follow more consults to completion, process significantly more electronic chart alerts daily, and perform a greater number of screening & annual exams.

Many times, even if the provider panel is near recommended sizes, the complexity of the panel requires that the provider must dedicate more time during/after each visit to address the needs of each complex patient. By necessity, high acuity patients with diabetes, strokes, autoimmune disorders, heart disease, kidney failure, liver disease, widespread joint disease, chronic pain syndromes, and/or other chronic disease states are given more provider attention. The providers screen for multiple potential symptoms, gather information on current daily functioning/symptom control, and review medications/labs to determine if the medical conditions are stable. Any needed studies or consults will require additional time to order, evaluate, and communicate to the Veteran and family.

In theory there should be an equal mixture of low, moderate, and high acuity patients to avoid overloading the provider. However, Phoenix VA primary care patient panel size is not routinely adjusted to reflect the high complexity of the patients on that panel. Many of the patient panels are stacked with a significant percentage of high acuity patients who compete for the provider's time. This results in the providers being overwhelmed trying to meet the needs of all the patients.

6. PVAHCS needs to provide more support for suicide prevention & outreach.

Although there is recruitment to hire additional staff, Suicide Prevention Team still doesn't have the full manpower needed to meet the needs of our PVAHCS population in terms of outreach, education, follow-up of Suicide Hotline calls, and case management of a group of Veterans deemed high risk for suicide.

Several years ago senior administration made the decision to stop taking quarterly reports from the Root Cause Analysis committee that reviews suicide cases to determine system processes that could be improved to prevent future suicides. After that time, the senior administration only got reports on the demographics of the suicide victims, not the underlying PVAHCS process that were involved in the case. Although the demographics are needed, it is important that senior administration have awareness of pertinent PVAHCS system issues.

Although the completion of Suicide Risk Assessment form (SRA) is mandatory in the mental health clinic, not all charts have updated/completed SRA. There have been 5 suicides of mental health patients with no SRA even though they were followed by a mental health provider at the time of suicide.

7. Service-connected Veterans who only desire specialty appointments for their service connected diagnoses are needlessly waiting PCP assignment for specialty care referral.

At the Phoenix VAMC, Veterans who are service connected frequently don't understand the process for accessing specialty care services. Not all service-connected Veterans want a VA primary care provider. If a service-connected (SC) Veteran only desires a specialty appointment for a specific service-connected medical problem, that Veteran does not need to wait for/have a VA primary care provider (PCP) assignment to obtain a specialty referral. Instead the SC Veteran only needs to contact the specialty clinic to arrange an appointment for evaluation of the service-connected medical problem.

V. Additional Comments on OIG Report

The VA Office of Inspector General (VA OIG) dedicated a tremendous amount of resources to explore allegations of pervasive problems within the Phoenix VA Health Care System (PVAHCS). In so doing, the VA OIG uncovered numerous problems involving scheduling irregularities, unofficial wait lists, culture goals emphasized at the expense of patient care, safety issues, and systemic obstacles to the proper provision of care in multiple areas.

Overall, the VA OIG investigation of PVAHCS produced massive systemic VA scheduling changes and led to a tremendous positive impact on the health care of our nation's Veterans. The Phoenix VA OIG inspection also revealed multiple problems that were outside the narrower focus intended for the original OIG investigation. As a result the Veterans Health Administration (VHA), Office of Medical Inspection (OMI), Office of Special Counsel (OSC), & Federal Bureau of Investigation (FBI) have since launched inquiries to explore those problems further.

In general, the clinical cases in the report are written so that those with a healthcare background would find it easy to evaluate the results. Unfortunately, the details and their implications often are not written in terms the layperson can understand.

The case study investigation limitations are implied but generally not directly identified by the investigators. I have no reason to believe that any information gaps in the 8/26/14 report were intentional. As I read the cases, I simply felt that there was more data needed to understand the implications and conclusions.

Not familiar with the basic OIG process, I was somewhat confused by the OIG's stance that bullying behavior was "unsubstantiated". They only reviewed 26 complaints. During my interview with investigators, I described behavior consistent with bullying. If I had been asked to provide the names of colleagues with direct knowledge of such behavior, I immediately could have provided the names of 3 current or former mid-level managers with first-hand accounts of numerous episodes of bullying or other workplace stress. The OIG had ample opportunity to ask each VA employee they interviewed about the PVAHCS environment and whether the employee was a victim of bullying or other intimidation. It should have been a routine part of the investigation, even if just to ascertain if an employee was afraid of repercussions for speaking with the OIG.

Although the investigation process was detailed in the 8/26/14 report, the basic OIG investigation process used in other investigations is unclear for those of us outside the OIG. For example, I turned in an OIG complaint in 2013 through my senator's office. My complaint dealt with serious issues including scheduling problems, suicide trends, facility safety issues, and other topics. Although I was told one OIG investigator was involved, there was never any official OIG report of the investigation into my complaint. The single email sent to my senator's office outlined a response from senior administration at the Phoenix VA. Within that 2013

response, they denied any abnormalities in the scheduling processes, suicide trends, & safety equipment. The OIG website has no record of any investigation conducted on the basis of my complaint.

I have been told that the VA OIG has discretion over which reports it places on its website. I am in possession of one such VA OIG case that is not listed on its website. This report is unfavorable to the VA and speaks of patient panels up to 50% over the recommended size, significant provider staff turn-over, and a negative administrative culture.

If the goal is transparency, then the VA OIG should place all summaries/full reports on its website.

STATEMENT OF THE HONORABLE ROBERT A. McDONALD
SECRETARY OF VETERANS AFFAIRS
BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
SEPTEMBER 17, 2014

Chairman Miller, Ranking Member Michaud, and Distinguished Members of the House Committee on Veterans' Affairs, thank you for the opportunity to discuss with you the Department of Veterans Affairs' (VA) response to the recent VA Office of Inspector General (OIG) report regarding wait times and scheduling practices at the Phoenix VA Health Care System (PVAHCS).

Let me begin by saying, I sincerely apologize to all Veterans who experienced unacceptable delays in receiving care at the Phoenix facility, and across the country. We at VA are committed to fixing the problems and consistently providing the high quality care our Veterans have earned and deserve in order to improve their health and well-being. We owe that to each and every Veteran that is in our care. We will continue to listen to Veterans, our VA employees, and Veterans Service Organizations (VSO) and use their feedback to improve access to quality care in Phoenix and across the country and we will work hard to rebuild trust with Veterans and the American public.

The VA OIG has released the final report of its review of issues with patient scheduling and access at PVAHCS. We have concurred with the recommendations in the final report and, in many cases, we have already taken action responding to the OIG's recommendations, improving processes and access to care for Veterans.

PVAHCS' Implementation of OIG Recommendations

The final OIG report is an update of the information previously provided by the OIG in its Interim Report issued on May 28, 2014, and contains final results from their independent review of the PVAHCS. In response to the report recommendations, we have outlined key action plans that expand access to care, improve staffing for primary care, and ensure accountability measures. All cases identified by OIG were reviewed,

and determinations regarding appropriateness of disclosures to patients and families are underway.

Currently at PVAHCS, we have a strong acting leadership team producing positive results. Glenn Costie is the Acting Medical Center Director and Elizabeth Freeman is the Acting Network Director. They are good people with a proven track record for serving Veterans and solving problems.

Based on the Interim report of the OIG, we began actions in Phoenix and across the country that have enhanced access for Veterans seeking care. In Phoenix specifically, we have taken the following actions:

Primary Care Staffing

PVAHCS leadership is increasing Primary Care staffing by 53 additional full-time equivalent employees. Aggressive recruitment and hiring processes have been implemented to speed this process. All services — physicians, nurses and clerks — have increased staffing in the clinics and Community-Based Outpatient Clinics (CBOC) and the facilities are securing contracts to utilize Primary Care physicians from within the community. Primary Care was recently added to the Patient-Centered Community Care contracts, and Health Net and TriWest are working to add Primary Care physicians to their networks nationwide including the Phoenix area.

Access to Care (wait lists)

PVAHCS, with support from the Veterans Health Administration's (VHA) Health Resource Center (HRC), has reached out to all Veterans identified as being on unofficial lists or the facility Electronic Wait List (EWL). PVAHCS completed 46,997 appointments in May, 48,970 appointments in June, and 50,629 appointments in July, for a total of 146,596 appointments completed at PVAHCS in three months.

As of August 15, 2014, there were 56 Veterans on the EWL at PVAHCS. PVAHCS is now scheduling the vast majority of patients directly into a Primary Care appointment when enrollment/registration occurs. Over 3,200 appointments have been made in Primary Care for new patients since this initiative began.

Access to Care (scheduling)

We announced on June 4, 2014, that the Department had reached out to all Phoenix, Arizona-based Veterans identified by the OIG as being on unofficial wait lists to immediately begin scheduling appointments for all Veterans requesting care. Nationally, VHA expeditiously deployed staff and resources from around the country to help PVAHCS identify patients waiting for care, clearing the way for them to get the care they needed. We have made progress and are publicly publishing data on our progress.

Access to Care (non-VA Care)

Clinical staff attempted to accommodate all appointments at PVAHCS. Where capacity did not exist to provide timely appointments, staff referred patients to non-VA community care in order to provide all Veterans timely access to care. From May 16, 2014 through August 28, 2014, PVHCS has made 14,622 referrals for appointments to community providers of non-VA care.

Since the Accelerating Care Initiative (ACI) began, resources have been provided to continue to work down the number of open consults even further. Since the beginning of the ACI, $24.9 million has been obligated as part of this initiative to provide community-based care for Veterans in the community.

Access to Care (new enrollees)

PVAHCS is hiring dedicated staff to complete on-line enrollment processing. VHA is developing an automated system for monitoring enrollment processing at PVAHCS and every VA facility. This monitor will track Veterans new to the VA and will assess the timeframe to their first appointment within the VA health care system. The data will be reviewed monthly with VISN 18 and PVAHCS leadership.

Locally, PVAHCS implemented process changes to ensure that Veterans receive appropriate care. To ensure continued success, patients waiting for care are reviewed daily and reported to facility and VISN leadership.

In July 2014, the Acting PVAHCS Director visited all CBOCs and local Clinics to observe the scheduling process and interact with scheduling staff to ensure all policies

are being followed to deliver Veterans the timely care they have earned. These interactions are now happening monthly across the country.

VA Nationwide

Since my confirmation as Secretary, I have traveled to VA facilities across the country speaking to employees and Veterans. I cannot overstate their enthusiasm for being part of the solution to our current challenges. Overwhelmingly VA employees are dedicated to serving Veterans. They are driven by strong institutional values that influence day-to-day behavior and performance: Integrity, Commitment, Advocacy, Respect and Excellence, I-CARE. On my first day as Secretary I asked all VA employees to join me in reaffirming our commitment to these core values and I directed VA leaders to do the same with the people that work for them. As we continue to move forward, our values help cultivate a climate where all employees understand what the right thing is and then does it. VA's way of doing business must conform to how we expect employees to treat Veterans and how we expect employees to treat one another. It is clear that somewhere along the line, some people's behavior was at odds with VA's mission and core values. It is up to the Department to reaffirm its worth and regain Veterans' trust. Over the past months, we have been forced to take a hard look at ourselves and the way we do business, listening to Veterans, employees, Congress, VSOs and other stakeholders.

Using their input, VA is in the process of rapidly deploying and instituting an array of changes aimed at fixing VA's problems. Beyond culture issues, demand outstripped supply. This contributed to an environment that led to violations of our mission and our values. Demand was increased by new presumptive conditions, twelve years of war, the economy and significant VA outreach and education efforts. Peak application of care for wars is decades after the conflict ends as Veterans age. This issue will be with us a long time. We have to build the appropriate capacity now.

We have initiated development of a more robust process for continuously measuring patient satisfaction at each site, and we will expand our patient satisfaction survey capabilities in the coming year, to capture more Veteran experience data

through telephone, social media, and on-line means. Additional VA-wide actions include:

Access to Care

- As of August 15, VHA has reached out to over 266,000 Veterans to get them off wait lists and into clinics.

  VA has re-doubled its efforts to provide quality care to Veterans and has taken steps at national and local levels to ensure timely access to care. VHA has developed the Accelerating Care Initiative (ACI), a coordinated, system-wide initiative designed to increase timely access to care for Veteran patients; decrease the number of Veteran patients on the EWL waiting longer than 30 days for their care; and standardize the process and tools for ongoing monitoring and access management at VA facilities. As of August 15, VA has decreased the number of Veterans on the EWL 57 percent. As we continue to address systemic challenges in accessing care, we are providing regular data updates to enhance transparency and provide the immediate information to Veterans and the public on improvements to Veterans' access to care. Data updates can be found on the following link: http://www.va.gov/health/access-audit.asp
- VA health care facilities nationwide continuously monitor clinic capacity in an effort to maximize VA's ability to provide Veterans timely appointments appropriate for their clinical conditions.
- Where VA cannot increase capacity, VA is increasing the use of care in the community through non-VA medical care. From May 16, 2014, through August 24, 2014, 975,741 total referrals to non-VA care providers have been made. That is 203,637 more non-VA care referrals than the same time period in 2013.
- Each of VA's facilities continuously reaches out to Veterans waiting longer than 90 days for care to coordinate the acceleration of their care.
- Facility clinical staff continuously evaluates Veterans currently waiting for care to ensure the timing of their appointment is medically appropriate for their individual clinical conditions.

- VA is decreasing the number of Veterans on the EWL by standardizing the process and tools for ongoing monitoring and access management at VA facilities.
- VHA utilizes call monitoring in its large national call centers. These monitoring practices require adequate telephony systems. VHA will introduce new monitoring practices through the VA Health Resource Center to assess scheduling practices performed by VA staff.

Scheduling

- The 14-day access measure was removed from all employee performance plans to eliminate any incentive for inappropriate scheduling practices or behaviors. In the course of completing this task, over 13,000 performance plans were amended.
- VA has suspended the use of Desired Date Performance Accountability Report (PAR) performance plans. VA is currently evaluating the use of Desired Date as a mechanism to assess patient preferred appointment timeframes.
- The VSOs are actively engaged in the process. We are updating the antiquated appointment scheduling system, beginning with near-term enhancements to the existing system and ending with the acquisition of a comprehensive, state-of-the-art, "commercial off-the-shelf" scheduling system.

Accountability

- At VA, we depend on the service of employees and leaders who place the interests of Veterans above and beyond self-interest. Accountability, delivering results, and honesty are key to serving our Veterans.
- Where willful misconduct or management negligence is documented, appropriate personnel actions will be taken—this also applies to whistleblower retaliation, which is unacceptable and intolerable at VA.

- VA Medical Center Directors and VISN Directors are completing face-to-face audits of their facilities' scheduling practices. The first round of face-to-face audits will be completed by September 30, 2014. So far, we have conducted 2,450 of these visits nationwide.
- On July 8, 2014, the Deputy Secretary announced that he ordered a restructuring of the Office of the Medical Inspector (OMI) to better serve Veterans and create a strong internal audit function. This restructuring will result in revisions to the policies, procedures, and personnel structure by which OMI operates and establish an internal audit group that will validate VHA's critical national performance measures.
- On August 7, 2014, I asked all VA employees and leadership to reaffirm their commitment to both our mission and "I CARE" values – Integrity, Commitment, Advocacy, Respect and Excellence. I intend this reaffirmation to be the first of many, to be repeated by each employee each year in March, on the anniversary of our establishment as a Department.

Patient Satisfaction

- We are building a more robust, continuous system for measuring patient satisfaction to provide real-time, site-specific information on patient satisfaction. We will augment our existing survey with expanded capabilities in the coming year to capture more Veteran experience data using telephone, social media, and on-line means. Our effort includes close collaboration with VSOs to plan our efforts. We are learning what other leading healthcare systems are doing to track patient access experiences.

Whistleblower Protections

We have made great strides in improving care and services to Veterans in Phoenix and nationwide because employees in Phoenix and elsewhere had the moral courage to do the right thing. They made their voices heard about what they saw

happening. Those employees are examples of I-CARE at its best. Our collective ability to deliver the best services and care to Veterans is inextricably linked to sustaining an organizational culture that protects and empowers the voices of all employees and leverages the diverse talent of all our human resources. This includes creating a climate that embraces constructive dissent, welcomes critical feedback and ensures compliance with legal requirements. As part of our commitment towards embracing this culture we have reinforced our commitment to whistleblower protections to all employees and VA recently registered for and published an implementation plan to receive certification from the Office of Special Council's Section 2302(c) Certification Program.

Accountability

We will continue to work with IG and other stakeholders to take appropriate action, but accountability is about more than personnel actions. We must focus on sustainable accountability. Sustainable accountability means ensuring all employees understand how daily work supports our mission, values and strategy. Sustainable accountability is about more than top-down, hierarchical behavior modification. It is collaborative. Supervisors provide feedback, every day, to every subordinate to recognize what is going well and identify where improvements are necessary. In that same spirit, employees fulfill their responsibility to Veterans and to the Department to provide feedback and input on how we can better serve Veterans.

To achieve sustainable accountability we will do a better job training leadership, flatten our hierarchical culture to encourage innovation and collaboration and we will rate the relative performance of employees because everyone cannot be *the* best. We have strong institutional values: I-CARE. These are mission-critical ideals that must profoundly influence our day-to-day behavior and performance. In performance that mission, guided by those values, we will judge the success of our efforts against a single metric – customer outcomes, Veterans' outcomes. We hold ourselves accountable to these standards. We do not want VA to meet a standard. We want VA recognized as *the* standard in health care and in benefits.

Conclusion

Mr. Chairman, the health and well-being of the men and women who have bravely and selflessly served this Nation remains VA's highest priority. By recommitting, as a Department, to our values, I know we can fix the problems and utilize this opportunity to transform VA to better serve Veterans. This concludes my testimony. Dr. Clancy and I are prepared to answer questions you or the other Members of the Committee may have.

Questions For the Record

October 7, 2014

The Honorable Richard J. Griffin
Acting Inspector General
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Griffin:

Committee practice permits the hearing record to remain open to permit Members to submit additional questions to the witnesses. In reference to our Full Committee hearing entitled, "Scheduling Manipulation and Veteran Deaths in Phoenix: Examination of the OIG's Final Report." I would appreciate if you could answer the enclosed hearing questions by the close of business on September 17, 2014.

In preparing your responses to these questions, please provide your answers consecutively and single-spaced and include the full text of the question you are addressing in bold font. To facilitate the printing of the hearing record, please e-mail your response in a **Word document**, to Carol Murray at Carol.Murray@mail.house.gov by the close of business on November 19, 2014. If you have any questions please contact her at 202-225-9756.

Sincerely,

MICHAEL H. MICHAUD
Ranking Member

MHM:cm

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

HEARING

SCHEDULING MANIPULATION AND VETERAN DEATHS IN PHOENIX: EXAMINATION OF THE OIG'S FINAL REPORT

SEPTEMBER 17, 2014
334 CANNON HOUSE OFFICE BUILDING

QUESTIONS FOR THE RECORD

FOR

Richard J. Griffin, Acting Inspector General, Department of Veterans Affairs

1. Please describe the process by which VAOIG reports are produced, from inception to the release of the final report, especially in regards to the process involving draft reports and agency comments.

    A. Please describe the process by which VAOIG reports are commenced.

    B. Please describe the process by which draft reports are made available to the Department of Veterans Affairs for comment.
        i). In what manner, physical or electronic, are draft reports transmitted or made available to VA?
        ii). Is there a specific office or individual to which drafts are made available? If the answer is dependent upon the subject matter of the report, please provide the names and titles of the specific offices and individuals to whom drafts are provided and briefly describe the process by which reports are routed to different offices and individuals.
        iii). In what manner, physical or electronic, are comments made by the VA regarding draft reports. In what manner are these comments transmitted or made available to the VAOIG? Are comments made once by the VA and transmitted or made available to the VAOIG, or does the process involve submitting updated drafts and receiving additional VA comments based upon the updated drafts?
        iv). Is there a formal process for reviewing agency comments and deciding whether or not changes should be made based upon these comments? Is this process informal or written?

2. Regarding the report "Review of alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System" (Phoenix Report) released on August 26, 2014, was the process as described in question 1 followed? If the process involving this report differed in any material way from the standard process involving VAOIG reports, please describe how the process in the case of the Phoenix report differed.

3. Based upon your knowledge of the practices and procedures of other Inspectors General in regards to obtaining agency comments on reports, are the practices and procedures of the VAOIG in this regard similar to the practices and procedures of other Inspectors General? Based upon your knowledge, are there material differences in practices and procedures relating to agency comments across the Inspectors General community?

4. The Executive Summary of the Phoenix Report states that the VAOIG was "unable to conclusively assert that the absence of timely quality care caused the deaths of these veterans."

   The New Oxford American Dictionary, Third Edition defines "conclusive" as "(of evidence or argument) serving to prove a case; decisive or convincing[.]" Black's Law Dictionary, Seventh Edition, defines "conclusive" as "[a]uthoritative; decisive; convincing <her conclusive argument ended the debate."

   A. Was "conclusively" as used in the sentence in the Executive Summary cited above consistent with these definitions?

   B. Is there another definition of "conclusively" that better captures the meaning as used in the cited sentence?

   C. If provided an opportunity to edit the cited sentence in order to better convey the meaning of the VAOIG, how would that sentence, as edited, read?

5. During the hearing, there seemed to be a great deal of confusion regarding the number of patient records reviewed and the extent of that review process.

   A. The Phoenix Report defines the NEAR list as a "computer-generated report" which "identifies newly enrolled veterans who requested an appointment during the enrollment process." In appendix B (Scope and Methodology) the report states that "OIG physicians reviewed the care provided to patients identified on the following lists" to include "deceased patients on the NEAR list after January 1, 2012." Please describe how this review was conducted since veterans listed on the NEAR list presuppose that they have not been provided medical care at the VA?

B. The Phoenix Report states that VAOIG "conducted a broader review of 3,409 patients identified from multiple sources, including the EWL, various paper wait lists, the OIG Hotline, the HVAC and other Congressional sources, and media reports." Please describe in more detail how you determined the universe of veterans' records you would review and how the number 3,409 was determined. In addition, please describe whether or not the 3,409 figure constituted a statistical sample.

6. The Phoenix Report contained 45 case summaries. Please describe how it was determined that these case summaries would be included in the Report and why these specific cases were included. In addition, please describe the process that led to a determination regarding what facts were included in the summaries and which were excluded and why this determination was made.

7. Please describe the process regarding the reviews involving patients who committed suicide. Do you have any response to criticism of those reviews? Is there anything you would like to clarify regarding the review process?

8. Can you comment on your efforts to identify the 40 veterans who were alleged to have died while on the Electronic Waiting List, and what was the outcome of your efforts?

9. The Phoenix Report states you identified "28 instances of clinically significant delays in care associated with access to care or patient scheduling. Of these 28 patients, 6 were deceased."

A. Please define what you consider to be a "clinically significant delay."

B. How certain is the VAOIG that these delays contributed to, or caused, these veterans' deaths?

DEPARTMENT OF VETERANS AFFAIRS
Inspector General
Washington DC 20420

December 1, 2014

The Honorable Michael H. Michaud
Ranking Member
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Michaud:

This is in response to your October 7, 2014, letter requesting information from the Office of Inspector General (OIG) following the Committee's September 17, 2014, hearing, "Scheduling Manipulation and Veteran Deaths in Phoenix: Examination of the OIG's Final Report." Enclosed are the responses to your additional hearing questions.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

/s/

RICHARD J. GRIFFIN
Acting Inspector General

Enclosure

Copy to: Chairman, Committee on Veterans' Affairs, U.S. House of Representatives

Office of Inspector General, Department of Veterans Affairs
Responses to Questions for the Record from the Minority Members of the Committee on Veterans' Affairs, U.S. House of Representatives
For a Hearing on September 17, 2014

1. **Please describe the process by which VA Office of Inspector General (OIG) reports are produced, from inception to the release of the final report, especially in regards to the process involving draft reports and agency comments.**

   A. Please describe the process by which VA OIG reports are commenced.

   OIG Response: The OIG conducts various types of reviews of VA programs and operations, including audits, evaluations, benefits inspections, healthcare inspections, and national healthcare reviews. We select areas to review based on financial risk, past program performance, and statutory requirements. We also conduct work based on requests from Congress, the VA Secretary, and complaints from veterans, their family members, and other citizens received through the OIG Hotline.

   When conducting an audit, the OIG, as well as other Government auditing agencies, follows the United States Government Accountability Office's *Generally Accepted Government Auditing Standards*, also known as the "Yellow Book." When the review is considered an inspection or an evaluation, the OIG follows the Council of the Inspectors General on Integrity and Efficiency's (CIGIE) *Quality Standards for Inspection and Evaluations*. The Standards were developed by CIGIE members as a framework for performing both inspection and evaluation work. The OIG adheres to these professional standards, which provide a framework for performing high-quality audit, inspections, and evaluations work with competence, integrity, objectivity, and independence, when issuing reports that help improve the effectiveness, efficiency, and economy of VA programs and operations.

   B. Please describe the process by which draft reports are made available to the Department of Veterans Affairs for comment.

   i). In what manner, physical or electronic, are draft reports transmitted or made available to VA?

   OIG Response: Draft reports are transmitted to VA program officials electronically with a memorandum that includes an advisement that since the document is a draft, the contents are subject to revision by the OIG prior to issuance of a final report, and for that reason recipients must not show or release the contents of the draft report other than for purposes of official review and comment. A copy of the memorandum transmitting the draft Phoenix report to the Acting VA Secretary was previously provided to the Committee Chairman and Ranking Member on October 15, 2014, in

response to earlier Questions for the Record from the Committee Chairman. A second copy is included for your convenience.

ii). Is there a specific office or individual to which drafts are made available? If the answer is dependent upon the subject matter of the report, please provide the names and titles of the specific offices and individuals to whom drafts are provided and briefly describe the process by which reports are routed to different offices and individuals.

OIG Response: OIG draft reports are addressed to the appropriate Under Secretary, Executive in Charge, or facility director as appropriate. Included in transmittal letters are specific instructions on how to respond to the report's findings and recommendations. We provide our draft reports to the following individuals who distribute the reports according to their specific office procedures:

- Veterans Health Administration (VHA) – Karen Rasmussen, Director, VHA Management Review Services
- Veterans Benefits Administration (VBA) – Kurt Hessling, Director, VBA Program Integrity and Internal Controls Staff
- National Cemetery Administration – Ronald E. Walters, Acting Under Secretary for Memorial Affairs
- Office of Information and Technology – LaPortia Pratt, Director, Project Coordination Service
- Office of Acquisition, Logistics, and Construction – Shana Love-Holmon, Chief of Staff
- Office of Management and Chief Financial Officer – Helen Tierney, Executive in Charge, Office of Management, and Chief Financial Officer

Most Healthcare Inspections draft reports (such as Combined Assessment Program reviews, Community Based Outpatient Clinics reviews, and reports pertaining to single facilities) are provided to the facility director, the appropriate Veterans Integrated Service Network director, and VHA Management Review Services.

Our Benefits Inspections draft reports are provided to the individual VA Regional Office and the VBA's Program Integrity and Internal Controls Staff. In some instances, when recommendations are directed to senior leadership in VBA, reports are issued to the Under Secretary for Benefits.

iii). In what manner, physical or electronic, are comments made by the VA regarding draft reports. In what manner are these comments transmitted or made available to the VA OIG? Are comments made once by the VA and transmitted or made available to the VA OIG, or does the process involve submitting updated drafts and receiving additional VA comments based upon the updated drafts?

OIG Response: VA's official response to draft reports is done electronically for both timeliness reasons and in order to facilitate inclusion of the comments and plans to implement report recommendations in the final report. However, depending on the issues in the report, OIG staff and VA staff may have discussions to clarify information in the report, including recommendations. These discussions are done via e-mail, or in discussions in person or by telephone. There may be one or multiple discussions, particularly with complex reports involving more than one OIG component or multiple issues. We may update a draft or we may not depending on whether the OIG decides that there is a basis for making a change. However, final comments are received once from each VA entity that has responsibility for concurring with and implementing recommendations

iv). Is there a formal process for reviewing agency comments and deciding whether or not changes should be made based upon these comments? Is this process informal or written?

OIG Response: The deliberative nature of the draft report review and comment process is consistent with the principle of Inspectors General as independent and objective units of Government and long-standing practice across the Inspector General community. This process provides VA with the opportunity to provide comments to ensure that the facts and findings are accurate, to obtain concurrence with recommendations, and have VA submit a plan to implement the recommendations. During this process, VA has the opportunity to raise factual issues and other concerns. To ensure each report is accurate and complete, we have an obligation to review the issues raised by VA and determine whether to make changes to the report or not. However, VA has no authority to demand that changes be made or impede the issuance of a report unless changes are made. Further, VA's response to each of our reports is included in the final report. When deemed necessary, we provide a rebuttal to information provided. This process ensures that VA is aware of the findings and held accountable to correct any deficiencies identified in the reports through our follow-up program.

2. **Regarding the report "Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System" (Phoenix Report) released on August 26, 2014, was the process as described in question 1 followed? If the process involving this report differed in any material way from the standard process involving VAOIG reports, please describe how the process in the case of the Phoenix report differed.**

OIG Response: The process for producing the Phoenix report did not differ in a material way from the standard process, with only two exceptions. Typically an exit conference is held with responsible VA program officials prior to or concurrent with the release of the draft report to explain the OIG's findings and recommendations and obtain preliminary feedback on the same. In light of our commitment to publish a final report in August 2014, an exit conference was not held due to time constraints. The second exception concerns the distribution of the draft report. At

the request of VHA, the report was sent only to one VHA addressee, the Director of VHA's Management Review Service.

3. **Based upon your knowledge of the practices and procedures of other Inspectors General in regards to obtaining agency comments on reports, are the practices and procedures of the VAOIG in this regard similar to the practices and procedures of other Inspectors General? Based upon your knowledge, are there material differences in practices and procedures relating to agency comments across the Inspectors General community?**

   OIG Response: VA OIG policies, procedures, and practices for preparing and issuing draft reports are consistent with those of the Inspector General community.

4. **The Executive Summary of the Phoenix Report states that the VAOIG was "unable to conclusively assert that the absence of timely quality care caused the deaths of these veterans."**

   The New Oxford American Dictionary, Third Edition defines "conclusive" as "(of evidence or argument) serving to prove a case; decisive or convincing[.]" Black's Law Dictionary, Seventh Edition, defines "conclusive" as "[a]uthoritative; decisive; convincing <her conclusive argument ended the debate."

   A. Was "conclusively" as used in the sentence in the Executive Summary cited above consistent with these definitions?

   OIG Response: The word "conclusively" was used to convey that we were unable to determine whether the delays in scheduling a primary care appointment caused any of the deaths. Our reviews and analyses were conducted by physicians, not attorneys, and thus were not focused on making legal determinations regarding causation. Accordingly, to accurately summarize the findings in the report, we did not want to use terms that could imply that our conclusions were speculative with respect to causation. The term "conclusively" as used in the Executive Summary is consistent with, and thus appropriately summarizes, the findings in the patient care summaries for the six veterans for whom there was a significant delay in scheduling a primary care appointment but who died prior to being seen, case numbers 1-5, and 27. For case number 2, we stated in the report: "Although unlikely to change the overall outcome for this patient, primary care management could have improved symptom control and assisted with specialty care coordination." For case number 3, we stated that the "delay in care for this patient was unlikely to have had a negative effect on his overall prognosis." For case number 27, we stated: "Better availability of an appointment for this patient might have changed the outcome." We did not make similar statements in the remaining three cases because despite the significant delays in scheduling primary care appointments, the records showed that the veterans did receive treatment at non-VA facilities and/or in other clinical areas at the Phoenix VA Health Care System, including in-patient care. Because we did

not determine whether the conditions that caused those hospitalizations would have been identified had a primary care appointment been scheduled more timely or whether earlier diagnosis would have made a difference in outcome, we could not reach a conclusion regarding whether the delay caused the death.

B. Is there another definition of "conclusively" that better captures the meaning as used in the cited sentence?

OIG Response: We are not aware of a term that more accurately summarizes our findings and conclusions in the cases discussed in the report with respect to the issue of whether any of the deaths were caused by the delays in obtaining primary care appointments

C. If provided an opportunity to edit the cited sentence in order to better convey the meaning of the VAOIG, how would that sentence, as edited, read?

OIG Response: We believe the sentence conveys our determination that we could not conclude that the delay in care resulted in the death of any of the veterans discussed in the report whose primary care appointments were not scheduled timely.

5. During the hearing, there seemed to be a great deal of confusion regarding the number of patient records reviewed and the extent of that review process.

A. The Phoenix Report defines the NEAR list as a "computer-generated report" which "identifies newly enrolled veterans who requested an appointment during the enrollment process." In Appendix B (Scope and Methodology) the report states that "OIG physicians reviewed the care provided to patients identified on the following lists" to include "deceased patients on the NEAR list after January 1, 2012." Please describe how this review was conducted since veterans listed on the NEAR list presuppose that they have not been provided medical care at the VA?

OIG Response: Those patients on the NEAR list who died after January 1, 2012, and had VA electronic medical records were reviewed. These patients were on the Phoenix facility's NEAR list because they were new enrollees at that facility, but had received prior care at other VA facilities The vast majority of veterans on the NEAR list were not part of the 3,409 cases reviewed.

B. The Phoenix Report states that VAOIG "conducted a broader review of 3,409 patients identified from multiple sources, including the EWL, various paper wait lists, the OIG Hotline, the HVAC and other Congressional sources, and media reports." Please describe in more detail how you determined the universe of veterans' records you would review and how

the number 3,409 was determined. In addition, please describe whether or not the 3,409 figure constituted a statistical sample.

OIG Response: During the course of this review, many lists were provided to the OIG that contained names of patients who were alleged to have been subject to delays in care, and therefore, may have been harmed by these delay. These lists were derived from multiple sources, including: congressional letters, the electronic wait list, the paper wait list, the schedule an appointment consult list, the NEAR list deaths, suicides, Phoenix physician reports, and the media. The total number of records identified from the lists reviewed was 3,562. The 3,409 represents the number of unique veterans, as some veterans were on multiple lists. The 3,409 was not a statistical sample. Rather, the number represents all the patients that met the criteria described in the methodology section of the report.

6. **The Phoenix Report contained 45 case summaries. Please describe how it was determined that these case summaries would be included in the Report and why these specific cases were included. In addition, please describe the process that led to a determination regarding what facts were included in the summaries and which were excluded and why this determination was made.**

   OIG Response: OIG physicians reviewed the electronic health records of all patients who died while included on a wait list or whose deaths were alleged to be related to delays in care. Physicians also reviewed the care provided for living patients identified from multiple sources following initial review and screening by OIG clinical staff.

   Cases considered by any reviewing physician to have quality of care deficiencies were then reviewed by other OIG physicians. Only cases where there was a consensus that quality of care was substandard were included in the report. In the course of this work, deficiencies clearly unrelated to delays were also identified and included.

   Case summaries were prepared with the intent of providing sufficient information to support the finding that there were significant delays or deficiencies in the care provided these veterans without violating any confidentiality laws or regulations.

7. **Please describe the process regarding the reviews involving patients who committed suicide. Do you have any response to criticism of those reviews? Is there anything you would like to clarify regarding the review process?**

OIG Response: The electronic health records were reviewed by OIG physicians, with either direct review or consultation with OIG board-certified psychiatrists. The process of chart review was as follows:

- Checked the date of death.
- Reviewed time frame and all appointments in the relevant tab of the electronic health record to determine (1) what appointments over time were cancelled by the clinic, by the patient, were pending, or completed, and (2) the temporal pattern/spacing of appointments.
- Reviewed the consult tab in the electronic record to see what consults had been placed and their disposition.
- Reviewed medical problem list.
- Looked for information to determine when the patients first visited the Phoenix VA Health Care System.
- Read the progress and consult notes in the progress note tab of the electronic medical record (including lab work) and related the timing of the visits to consult requests and appointments.
- Reviewed records to determine what other VA facilities the patient was seen at and reviewed relevant notes.
- Categorized care as having a delay, a delay with clinical significance, a poor quality of care issue, or none of these.

There has been criticism of determinations regarding causality in some of the cases based on the limited information included in the case summaries. However, those critics made inaccurate assumptions and did not understand or consider the need to restrict information in the report to ensure compliance with confidentiality laws and regulations.

8. **Can you comment on your efforts to identify the 40 veterans who were alleged to have died while on the Electronic Waiting List, and what was the outcome of your efforts?**

   OIG Response: OIG staff interviewed Dr. Foote and asked directly several times for the list of 40 veterans that was discussed at the April 9, 2014, House Veterans' Affairs Committee hearing and in the media. He indicated that he did not have the list and that he had provided the names to the Committee. The Committee provided OIG with a list of 17 names. Dr. Foote did not provide the OIG with the names of the 40 veterans in question. Based on our review of Phoenix electronic records, we were able to identify 40 patients who died on the Electronic Wait List during the period April 2013 through April 2014.

9. **The Phoenix Report states you identified "28 instances of clinically significant delays in care associated with access to care or patient scheduling. Of these 28 patients, 6 were deceased."**

A. Please define what you consider to be a "clinically significant delay."

OIG Response: A clinically significant delay is a delay that has a substantial impact on the quality of a patient's medical care. In many cases, an impact on the patient's well-being due to delay in care was impossible to discern.

B. How certain is the VAOIG that these delays contributed to, or caused, these veterans' deaths?

OIG Response: As we have said all along, we could not conclusively prove the deaths were caused by delays. That we found "clinically significant delays" plainly means that there was a negative impact on these veterans' care and in that sense the delays may have contributed to their deaths. To what extent the delays contributed to these deaths could not be determined. It is up to the judicial system to make a legal determination regarding cause or contribution, not the OIG clinical staff.

October 7, 2014

The Honorable Robert A. McDonald
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

Committee practice permits the hearing record to remain open to permit Members to submit additional questions to the witnesses. In reference to our Full Committee hearing entitled, "Scheduling Manipulation and Veteran Deaths in Phoenix: Examination of the OIG's Final Report." I would appreciate if you could answer the enclosed hearing questions by the close of business on September 17, 2014.

In preparing your responses to these questions, please provide your answers consecutively and single-spaced and include the full text of the question you are addressing in bold font. To facilitate the printing of the hearing record, please e-mail your response in a **Word document**, to Carol Murray at Carol.Murray@mail.house.gov by the close of business on November 19, 2014. If you have any questions please contact her at 202-225-9756.

Sincerely,

MICHAEL H. MICHAUD
Ranking Member

MHM:cm

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

HEARING

SCHEDULING MANIPULATION AND VETERAN DEATHS IN PHOENIX: EXAMINATION OF THE OIG'S FINAL REPORT

SEPTEMBER 17, 2014
334 CANNON HOUSE OFFICE BUILDING

QUESTIONS FOR THE RECORD

FOR

Robert A. McDonald, Secretary of Veterans Affairs

1. During the hearing, Secretary McDonald mentioned that he has cut the Office of Secretary staff. Please provide the names and titles of the staff referred to and whether these individuals were reassigned, and if so, where were they reassigned? Please describe why these actions were taken.

2. Please describe the process by which draft reports from the VAOIG are made available to the Department of Veterans Affairs for comment.

    A. In what manner, physical or electronic, are draft reports transmitted or made available to VA?

    B. Is there a specific office or individual to which drafts are made available? If the answer is dependent upon the subject matter of the report, please provide the names and titles of the specific offices and individuals to whom drafts are provided and briefly describe the process by which reports are routed to different offices and individuals.

    C. In what manner, physical or electronic, are comments made by the VA regarding draft reports. In what manner are these comments transmitted or made available to the VAOIG? Are comments made once by the VA and transmitted or made available to the VAOIG, or does the process involve submitting updated drafts and receiving additional VA comments based upon the updated drafts?

D. Is there any written policy or guidance regarding the process the Department undertakes in providing the VAOIG with comments regarding draft reports? If so, please provide the Committee with this written policy or guidance. If the process is more informal, please explain how the process has evolved and whether there has been any material change in the process over the last three years.

3. Regarding the report "Review of alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System" (Phoenix Report) released on August 26, 2014, was the process as described in question 2 followed? If the process involving this report differed in any material way from the standard process involving VAOIG reports, please describe how the process in the case of the Phoenix report differed.

Questions for the Record
House Committee on Veterans' Affairs
Scheduling Manipulation and Veteran Deaths in Phoenix:
Examination of the OIG's Final Report

September 17, 2014

Questions for the Record from Congressman Michael Michaud

Question 1. During the hearing, Secretary McDonald mentioned that he has cut the Office of Secretary staff. Please provide the names and titles of the staff referred to and whether these individuals were reassigned, and if so, where were they reassigned? Please describe why these actions were taken.

VA Response: The Office of the Secretary has taken action to reduce overall staffing as appropriate and continues to look for other opportunities for greater efficiencies. The following positions are vacancies in the Office of the Secretary where there are no plans to backfill. Reason for the vacancy follows the position:

Executive Writer for the Secretary – Position and individual reassigned to the Office of Public and Intergovernmental Affairs;
White House Fellow – Expired term appointment;
Senior Advisor for DoD/Interagency – Expired term appointment;
Staff Assistant/Travel Coordinator – Reassigned due to promotion;
Staff Assistant/Travel Coordinator – Reassigned due to promotion; and
Program Assistant for Center for Faith-Based and Neighborhood Partnerships – Incumbent left the Agency.

Question 2. Please describe the process by which draft reports from the VAOIG are made available to the Department of Veterans Affairs for comment.

A. In what manner, physical or electronic, are draft reports transmitted or made available to VA?

VA Response: If the draft report contains recommendations to the Under Secretary for Health, the responsible Inspector General (IG) auditor, inspector, or investigator transmits the draft report electronically to the Veterans Health Administration (VHA).

B. Is there a specific office or individual to which drafts are made available? If the answer is dependent upon the subject matter of the report, please provide the names and titles of the specific offices and individuals to whom drafts are provided and briefly describe the process by which reports are routed to different offices and individuals.

VA Response: If the draft report contains recommendations to the Under Secretary for Health, the responsible IG auditor, inspector, or investigator transmits the draft report to VHA's Management Review Service. If the recommendations in the draft report are to the Veterans Integrated Service Network (VISN) or facility director, the IG transmits the draft report to the respective VISN or facility director.

C. In what manner, physical or electronic, are comments made by the VA regarding draft reports. In what manner are these comments transmitted or made available to the VAOIG? Are comments made once by the VA and transmitted or made available to the VAOIG, or does the process involve submitting updated drafts and receiving additional VA comments based upon the updated drafts?

VA Response: VHA communicates with the responsible IG auditor, inspector, investigator, or relevant team in a variety of ways. Comments are made during calls or meetings; some comments are provided in writing; and some comments are submitted in VHA's final response to the report either as technical comments or incorporated into the memo from the Under Secretary for Health. The responsible IG officials determine whether the comments clarify inaccuracies or inconsistencies in the draft report and send VHA a revised draft containing any changes. VHA seeks clarification of confusing draft content, including revised content, before generating an action plan and transmittal memo for signature by the Under Secretary for Health.

D. Is there any written policy or guidance regarding the process the Department undertakes in providing the VAOIG with comments regarding draft reports? If so, please provide the Committee with this written policy or guidance. If the process is more informal, please explain how the process has evolved and whether there has been any material change in the process over the last three years.

VA Response: The process of providing comments to the Office of Inspector General (OIG) on draft reports is informal. When OIG issues their draft report to VHA, OIG establishes a deadline for receipt of VHA's response. The administration reviews the draft report and develops appropriate action plans in response to the recommendations. If upon reading the draft report VHA finds inaccuracies, inconsistencies, or confusing content, VHA communicates with the IG team as soon as possible. Once the Under Secretary for Health concurs on and signs VHA's response to the draft report, VHA transmits the response back to OIG electronically. The process has neither evolved nor undergone any material changes over the last three years.

Question 3. Regarding the report "Review of alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System" (Phoenix Report) released on August 26, 2014, was the process as described in question 2 followed? If the process involving this report differed in any material

way from the standard process involving VAOIG reports, please describe how the process in the case of the Phoenix report differed.

VA Response: With regard to OIG report 14-02603-267 "Veterans Health Administration: Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System," the process described in question 2 was followed with one exception: the draft report was sent to VHA's Management Review Service even though all of the recommendations were to the Secretary of Veterans Affairs. Consequently, the final response to OIG was a joint response from the Secretary of Veterans Affairs and the Under Secretary for Health.

Consistent with the process described in question 2C, for the Phoenix report, VHA received the initial draft report and additional revised drafts that contained minimal changes reflecting accuracy and clarity as the deliberate review process between OIG and VHA progressed forward to the final report. During his testimony, the IG confirmed the appropriateness of this iterative review process to ensure clarity and accuracy and to receive the concurrence or non-concurrence to the recommendations along with the submitted action plan to address the recommendations.

○